MASSACHUSETTS CAUCUS OF WOMEN LEGISLATORS TASK FORCE ON PREGNANT AND PARENTING TEENS

Representative Patricia G. Fiero, *Chairperson*

ADOLESCENT HEALTH CARE: PART II

Compiled by
Marion McCarthy
Senior Research Analyst
April, 1988

George Keverian, *Speaker*
House of Representatives

PREGNANT AND PARENTING TEENAGERS IN MASSACHUSETTS

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Researched and Compiled by:
Marion McCarthy, *Senior Research Analyst*

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Adolescents and Their Health

While teenage pregnancy, early childbearing and parenthood, and their consequences are the main focus and concern of this report, they must be viewed in the context of the many personal, social, environmental, physical and mental health problems that are confronting adolescents, and being experienced by them in society today. These problems must be placed in the full range of adolescent needs, and in the dynamics of all developmental stages throughout adolescence.

There are over 20 million 15 to 19 year old adolescents in the United States. There are another 18 million 10 to 14 year old pre-adolescents and adolescents following along behind them.

Recent studies indicate an increasing concern about the overall poor health of adolescents in the United States today.[1] Some research implicates the lifestyle factors of diet, exercise, and stress in the poor health of teenagers. Once thought to be an "invincible" group in society, adolescents are now considered as being physically unfit and generally unhealthy. Since the early 1960's, "the general health of adolescents has declined", stated Dr. Joseph Zanga, chairman of the American Academy of Pediatrics' Committee on School Health, in a recent study of the health status of adolescents.

Research results from several studies in the United States confirm these concerns. One study from the Missouri Health Department states that "two-thirds of the students who had registered in the school health programs indicated they probably would not have sought medical services for their presenting problems at another facility." Over one-half of the students had no regular physician, and almost 20% could not remember the last time they had seen a doctor. Many studies confirm the fact that 4 to 6 out of every 10 adolescents in the United States are not receiving regular health services.

Research Studies on Health

According to data from the National Ambulatory Care Medical Survey, 35 million visits were made to private physicians by 15-19 year olds in 1981, with an average of 1.8 visits per person. Over 1-1/2 million 15-17 year olds, and almost 1 million 18-19 year olds visited a physician for a general medical examination in that same year.

An article in "Youth Law News"[2] states, "children between the ages of 11 and 20 years have the lowest physician visit rate of any age group. Pre-teens and teens actually have a higher rate of medical conditions requiring immediate care than any other age group. For those living in poverty, the rate is much worse." The article indicates that for poor children and youth under 17 years of age, who are in fair or poor health, physician visits were less than half of those made by children and youth of similar health status, but with higher family incomes.

Joy Dryfoos, in a research study for the Rockefeller Foundation, titled, "School-Based Clinics: Serving Adolescents Where They Are"(1985), stated, "when adolescents make these visits to their family physicians, surgeons, pediatricians, or other doctors, it is unlikely the physician will initiate discussions or undertake exams that will lead to prevention of "problem behaviors", such as drug or alcohol abuse or unwanted pregnancy".[3] The article also states that adolescents are usually afraid to discuss problems they are experiencing with a physician, if

they have a physician. They avoid talking about crises they are experiencing, and would often rather walk into an emergency room for treatment. Already-overloaded emergency rooms report excessive utilization by adolescents for accidents, sudden illnesses, over-doses, and deliveries. For many disadvantaged and poor youth, and for those experiencing other barriers to care, seeking help at a hospital emergency room or treatment center, if help is sought at all, is the only recourse left open to them.

Problem Behaviors

In addition to difficulties in accessibility and availability of health services and other support programs for pre-adolescents and adolescents, the American Academy of Pediatrics' Committee on School Health states, "countless adolescents today are going through severe emotional turmoil without the help, support, and guidance they need." A national Commission on Mental Health reported that adolescents are the most underserved population in the country.(1986)

While adolescence should be a relatively healthy time of life, "the health effects of the problem behaviors are significant, documented by the high rates of alcohol and drug abuse, suicide and psychiatric admissions among this age group. Certain adolescents have little access to private medical care."[4] Teenagers are reporting more psychosomatic symptoms than ever before, and are experiencing higher rates of stress-related syndromes than in the previous two decades.

Most widespread of the destructive activities young people take part in are drug abuse, alcoholism, and reckless driving. Suicidal acts and drug abuse are symptoms of deep psychological pain, despondency, depression, feelings of worthlessness and helplessness. In addition, there is increasing concern about rising teen rates in sexually transmitted diseases, deaths, and, in some parts of the country and Massachusetts, early pregnancy and parenting. The potential for child-adolescent abuse and neglect is an area of serious concern.

In 1981, national health statistics revealed that young people between the ages of 15 and 24 years comprised the only age group in the United States with a higher mortality rate in 1979 than in 1960. An article titled, "Development of Community-Based Health Services for Adolescents at Risk for Sociomedical Problems", states, "large numbers of young people suffer from serious, if nonfatal, health and health-related problems, such as sexually transmitted diseases, unplanned pregnancies, alcohol and drug-related problems, episodes of violence, and mental illness. The severity of these problems is compounded because many young people suffer from several problems simultaneously."[5]

Adolescents are also vulnerable to a range of children's health problems, such as the flu, colds, dental problems, and other similar types of health problems. However, for adolescents, health and health-related needs are frequently coupled with the consequences of risk-taking behavior that is very common in this population. For teens, health problems are frequently medical manifestations of problems having a social origin. The average age at which risk-taking behavior begins is steadily declining - these behaviors are starting at younger ages.[6]

Education and Employment Training

In addition, teenagers are dropping out of school at increasing rates, are experiencing serious problems in achievement in school, are often lacking in the necessary skills, abilities, and capacity to succeed, and are frequently ill-

equipped and unprepared to make the transition out of school - if they are in school- and into the job market, or to enter higher education. Many experience serious difficulties in developing literacy skills, mathematical skills, and other basic competencies that are essential to progressing in school, the job market and employment training, the assumption of responsible roles in society, and the self-sufficiency and basic foundations that are necessary for continued growth and development.

Health Care

The Children's Defense Fund in Washington, D.C.(1987), has documented that nearly every state has recognized and identified adolescents as a desperately underserved population, and one that frequently does not have a source of health care.

For those adolescents who do seek health care services, there is often an experience of frustration, dissatisfaction, and unmet needs when confronted by a fragmented health system that is not designed to meet the comprehensive needs of developing adolescents. Also, according to the Youth Law News article (1986), and many other sources, health care services for teens are seldom available in locations that are convenient for teens, or during hours that do not clash with school and work schedules. Also, and a critical motivational factor, adolescents often regard health care as a low priority. Even when they do seek health services, they do not always follow directions, fill prescriptions, follow-up on visits, or follow through with referrals.

The article in Youth Law News states, "with a segmented, episodic approach to health care, many adolescents fall through the cracks." Studies show that teenagers will use health care services if they are conveniently located, are free or low cost, are confidential, comprehensive, and provided by staff trained in caring for the needs of adolescents.

A recent study in Youth Law News (1986)[7] compared the use of comprehensive services designed for adolescents with the segmented services of traditional clinics and found that the comprehensive clinics served a higher percentage of teenagers in their specific geographical areas.

Dryfoos states,[8] "adolescents need to know how to obtain good health, how to gain good health, and how to maintain it. They need to be able to know which behaviors to obtain and which to avoid." The study continues by stating that the ideal system for adolescent health care would encompass both promotion of good health habits and the treatment of problems. Programs should also involve medical, social, educational, and psychological interventions.

Research cited in the "Development of Community-Based Health Services for Adolescents at Risk for Sociomedical Problems" states, "the U.S. health care system has not responded well to young patients with multiple problems. Few health care providers are trained in adolescent health care. Available care, especially for low-income young people, tends to be fragmented and offered at separate clinic sites. Moreover, young people tend to delay treatment because of difficulties in access and a desire to avoid dealing with complex institutions."[9]

Health Care and Poverty

All health problems, whether behavior-related or not, are seriously exacerbated by the profound effects of poverty. National Health Surveys show that those

living in poverty are much more likely to assess their health as fair or poor than are those with higher incomes. The Dryfoos article states, "disadvantaged youth are more hampered by a rapidly deteriorating social environment, with decreased employment opportunities."[10]

The Youth Law News article points to additional problems that create barriers to health care and other services for adolescents. While poverty is a major barrier, and one that affects all age groups, teens often face other obstacles such as parental consent requirements and perceived or actual lack of confidentiality. Lack of a source of payment independent of parents can also be a deterant to teens seeking help.[11]

In addition to an overall lack of, or inadequacy of, general health care and health promotion among a large number of adolescents and pre-adolescents, "at very early ages, advantaged children are told more about maintaining health than are disadvantaged children."[12] This applies also to adolescents, and involves the consistency and quality of the level of availability, accessibility, and affordability of health care and health promotion in their lives.

Adolescent Development

The teen years are the time when various needs, issues, and growth patterns are emerging and confronting adolescents. How these are met and resolved are of significance to individual maturity, fulfillment, and ability to participate in, and function competently and comfortably within one's own life experiences and society at large. The developmental stages of adolescence recognized are:[13]

the ability to trust and to think well of oneself
the establishment of an individual separate identity
the capacity to become involved in healthy, intimate love relationships
the capacity to function independently
an appetite for growth and new experience and to perform work that is both gratifying and meaningful

Clearly, any and all of the problems described, along with too-early pregnancy and parenting, and the serious long-term consequences that frequently accompany childbearing among young teens, interfere with, and disrupt these developmental tasks and their successful resolution. This, then, interrupts the life experiences and life options for these young people, in the present, and in their future.

Pregnancy, Childbirth, and Parenthood

In the latter half of this century, teenage pregnancy has been cited as one of the major public health and social problems of our time - a problem closely associated with poverty and its consequences. The number of premature infants and infants born with illnesses and developmental disabilities, the infant mortality rate, the health complications to mother and child, and the number of deaths among the teenagers themselves, as compared to older women who give birth, are all a source of serious concern. Along with these health matters, "there is an extraordinary effect of these pregnancies upon our society: teenagers and their children must be housed, fed, clothed, educated, and cared for, which calls for an

enormous commitment of government and private resources."[14] The teenager who attempts to complete her education, care for the child, and tries to work towards becoming self-sufficient, is all too often crushed by the realities of early pregnancy and childbearing.

Teenage pregnancy and early childbearing are frequently accompanied by a full range of associated problems, often experienced in complex behaviors. These problems and behaviors must be viewed, and addressed in full, if a complement of programs and network of services are to be implemented in any effective preventive and interventive manner. Many pregnant and parenting teenagers also experience sexual and physical abuse, substance use and abuse, depression, become runaways and homeless, and a wide range of social, health, educational and economic problems - before, during, and after pregnancy and childbirth.

Teen Pregnancy Statistics

The fact that teenage pregnancy and childbirth have been recently brought to the forefront of national attention, and gained widespread media coverage and concern, does not mean that the problem itself is a recent one. There have always been relatively large numbers of teen parents, but public awareness has now begun to catch up with the problem in terms of confrontation of the issues, and in terms of solutions afforded to adolescents to help them to resolve the issue. Also, more is now known about the associated factors of poverty, the lack of education, and the personal characteristics of this population.

Each year, over one million teenage women become pregnant in the United States. Over half a million give birth. About 40% of those who become pregnant have an abortion; about 13% have miscarriages. Over 30% of all abortions in the United States are to teenagers. Teenagers account for 16-20% of all births, and 28% of all first births. According to the Center for Population Options in Washington, 1 out of every 3 female American women become pregnant before age 20.

According to the National Center for Health Statistics, there are 1.1 million teenage mothers in the United States. Teenagers are having babies at younger ages. About 93% of teens who give birth decide to keep their babies and raise them on their own. In 1965, 35% of teenagers who gave birth placed their babies for adoption. In 1985, only 5% decided to place their babies. About 30% of these mothers become pregnant again within two years; 20% become pregnant again within a year.

In a research report titled, "Adolescent Pregnancy: Whose Problem Is It?", the Children's Defense Fund states that each day:[15]

* more than 3,000 teen women become pregnant

* teenage women give birth to 1,300 babies: 800 of these have not completed school; 100 have not completed the 9th grade

* 500 school-age teens have abortions

* 26-13 and 14 year olds have their first child; 13-16 year olds have their second child

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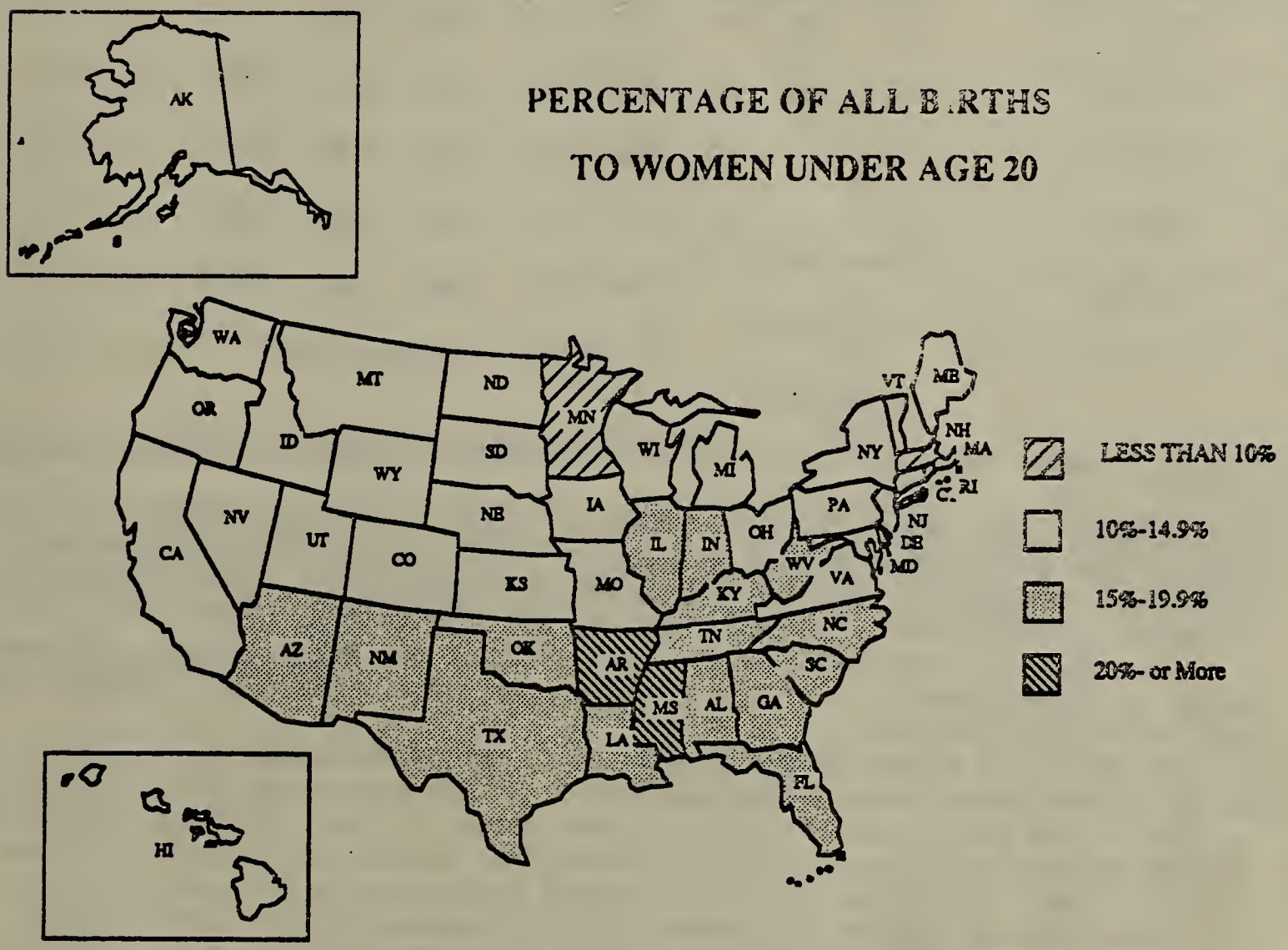
The following map represents the percentage of all births to women under age 20 across the country.



Source: Preventing Teenage Pregnancy: A Public Policy Guide. Susan E. Foster, The Council of State Policy and Planning Agencies, Wash. D.C., 1986.

Findings in Massachusetts

While the numbers of teenage births and birthrates are declining nationally, in general, there are recent indications in Massachusetts that birthrates have slightly increased. In 1984, teen births numbered 7,016; in 1985, teen births numbered 6,970. However, teen births among 15 year olds and under increased from 349 to 408 between 1984 and 1985, an increase of 59 births in this age group. Between 1983 and 1984, there was an increase in this age group, from 341 to 349.

The following chart states the numbers of births, by age of the mother, for the five year period of 1981 to 1985, with totals and the percent of teen births to total births for each year.

Year	Total Births	Age of Mother 12	13	14	15	16	17	18	19	Totals 12-19	% of Total Births
1981	73,931	1	12	82	275	722	1357	2164	2816	7,429	10.0
1982	75,749	1	14	83	299	753	1328	2101	2722	7,361	9.7
1983	76,031	0	8	78	255	726	1278	2053	2521	6,919	9.1
1984	78,198	9 (combined)		75	265	714	1307	2061	2585	7,016	9.0
1985	81,776	113 (combined)			295	698	1283	1986	2595	6,970	8.5
1986		97 (combined) 12-14			combined 15-19=6,754					6,851	

Data Source: Mass. Dept. of Public Health: Division of Health Statistics and Research.

From 1984 to 1985, there was an increase in births to younger teens, ages 12-14, of 29 births. From 1985 to 1986, births to teens ages 12-14 decreased by 16. The numbers of teenagers in the state, including younger teens, are declining (see p.8). Births to 15 year olds increased by 30 births from 1984 to 1985.

According to yearly statistics from the Dept. of Public Health, of teenage births in Massachusetts, over the five year period of 1982-1986, teenagers gave birth to 35,117 babies.

Of the total births to teens ages 15-19, in 1984, 1,126, or 16%, were repeat births to mothers already having one child. Of the total teen births, ages 15-19, in 1984, 5,449 were first births, 965 were second births, 145 were third births, 12 were fourth births, and 2 were fifth births. Of the total births to teens ages 15-19, in 1985, 1,131, or 16.2% were repeat births of the 2nd and 3rd child.

While teenage mothers gave birth to 7,016 babies in 1984, for many this was not their first child. When repeat births are figured for the total number of children these mothers had, the numbers added up to a combined total of 7,884 children for that year alone. When repeat births are figured for 1985, teen mothers had over 8,000 children, when 2nd and 3rd children are counted.

The following chart states teen births, ages 15-19, in Massachusetts the teen female population, ages 15-19, and the birthrate for teens in this age group, for the five year period 1982 to 1986.

Teen Birthrates in Massachusetts, 15-19 years, 1982-1986

Year	#Teen Births Ages 15-19	Female Teen Population Ages 15-19	Birthrate 15-19
1982	7,263	249,586	29.1 per 1,000
1983	6,833	245,266	27.8 per 1,000
1984	6,932	236,575	29.3 per 1,000
1985	6,857	230,183	29.7 per 1,000
1986	6,754	221,500 (approx.)	30.5 per 1,000

Data Source: Mass. Dept. of Public Health

As stated in the above chart, the teenage birthrate for 15-19 year olds increased from 27.8 per 1,000 in 1983 to 29.3 in 1984, to 29.7 in 1985, and increased again to 30.5 in 1986. The birthrates for younger teens, ages 12-14, for 1985 was 13.5 per 1,000, and for 1986 was 13.0 per 1,000.

Teen Births by Race

In 1984, of the total of 7,016 births to teenagers in Massachusetts, 5,766, or 82%, were to white teenage women. Of the total births to teens, ages 12-19, 1,043, or 14.8% were to teenage women who were black, Hispanic, and other race/ethnic groups.

In 1985, of the total of 6,970 births to teenagers in Massachusetts, 4,697, or 67.4% were to white teenage women. Of the same total births to teens, ages 12-19, 1,080, or 15.5% were to teenage women who were black. Hispanic teen births totaled 848, or 12.2% of the total teen births.

The following chart states the numbers of teen births to white, black, and Hispanic teenagers, in age groups, for 1985:

Maternal Age	All Races	Hispanics	Whites	Blacks
12-15 years	408	83	186	103
16-17 years	1,981	281	1,244	359
18-19 years	4,581	484	3,267	618

Data Source: Mass. Dept. of Public Health, Division of Health Statistics and Research

For younger teens giving birth, the number of 408 births is the highest number of births to this age group in recent years.

The population in Massachusetts, in 1985, of 15-19 year old white female* teenagers, was 206,062. The total births to white teenagers was 4,659, in this

* Caution must be used in the interpretation of race/ethnic group statistics. Races are often mixed, as when Hispanics are combined with whites. Data is based on provisional population statistics.

age group, giving a birthrate of 22.6 per 1,000. The total female black population in 1985, ages 15-19, was 12,858. The total births to black teenagers in that age group was 1,043, giving a birthrate of 81.5 per 1,000. For teenagers, ages 15-19, who were Hispanics and other race/ethnic groups, the population was 11,263. The number of births in this group was 1,268, giving a birthrate of 112.2 per 1,000. *

Abortion Statistics

In 1983, in Massachusetts, teen women ages 13-19 years, had 8,881 abortions. In the same year, school age teens, 13-17 years, had 2,672 abortions. Teen abortions for ages 13-19 accounted for 23.8% of all abortions for that year. School age abortions accounted for 14.5% of all abortions.

In 1984, teen abortions for ages 13-19 numbered 7,522, a decrease** of 1,359. Teen abortions accounted for 23.5% of all abortions in 1984.

In 1985, the number of abortions for teens, ages 15-19 years, was 8,153, and the number of abortions for teens under 15 years was 201, with a total of 8,354 abortions for teens less than 15 through 19 years. This was an increase of 832 abortions in this age group. Teenage abortions accounted for 23.2% of all abortions in 1985. School-age abortions accounted for 3,087 of all teenage abortions in 1985.

In 1986, the number of abortions for teens, ages 13-19, was 9,814, an increase of 1,460 over 1985.

A breakdown of numbers of births and abortions to teenagers for the five year period of 1981 to 1985, and recent statistics for 1986, **in in Table 1.**

Of the 14,254 teenage women who became pregnant and either had an abortion or gave birth, ages 15-19, in 1984, 51.4% had an abortion and 48.6% gave birth. Of the 15,010 teens 15-19 who became pregnant and either had an abortion or gave birth in 1985, 54.4% had an abortion, and 45.6% gave birth. In 1986, of teens ages 15-19, 16,323 became pregnant: 58.6% had an abortion, and 41.3% gave birth. Pregnancies increased for teens 12-19, from 1985 to 1986, by 1,341.

Over the five year period of 1982 to 1986, teenagers 12-19 had a total of 35,117 births and 44,091 abortions. The increase in abortions in 1985 is the first increase in the five year period 1981 to 1985, and a further increase occurred in 1986. From 1984 to 1986, the percentage of abortions increased, while the percentage of births decreased.

The following chart states the numbers and percentages of teens, ages 12-17, who became pregnant and had an abortion, or gave birth, for the period of 1981 to 1985.

Year	#Births	%age	#Abortions	%age
1981	2449	42.1%	3365	57.8%
1982	2478	46.8	2806	53.1
1983	2345	46.7	2672	53.2
1984	2370	50.4	2328	49.5
1985	2389	43.6	3087	56.3

* Data Source: DPH: Division of Health Statistics and Research, Provisional Population Approximations.

** Abortion numbers may be influenced by more or less reported numbers in each year.

The percentage of births in this age group decreased, while the percentage of abortions increased in 1985, for school-age teenagers.

In 1983, 535 young teens, ages 12-15 became pregnant. Of these, 341 gave birth, and 194 had abortions. In 1984, 549 teens in this age group became pregnant. Of these, 349 gave birth, and 200 had abortions. In 1985, 609 teens in this age group became pregnant. Of these, 408 gave birth, and 201 had abortions.

Teen Births in Massachusetts Cities and Towns

The top ten cities in numbers of births to teenagers in 1984 were:*

City/Town	#births	%total births**	School Age, 12-17
Boston	1132	13.2%	438
Springfield	504	19.2%	198
Worcester	312	12.9%	101
Lowell	248	14.4%	92
Lawrence	246	18.8%	101
Fall River	234	16.9%	75
New Bedford	232	15.7%	79
Brockton	226	13.9%	72
Lynn	156	11.8%	69
Holyoke	141	18.8%	63

The top ten cities in numbers of births to teenagers in 1985 were:

	#births	%total births	School Age 12-17
Boston	1192	13.3%	468
Springfield	418	15.8%	175
Worcester	316	12.0%	116
Lawrence	273	18.0%	100
Lowell	261	14.9%	86
Brockton	242	13.9%	89

* Data Source: DPH, Division of Health Statistics and Research
** Means the percent of teen births to total births for that city or town.

Fall River	240	17.5%	74
New Bedford	223	15.0%	81
Holyoke	188	23.3%	74
Lynn	173	12.6%	60

Increases in teenage births occurred in Boston, Worcester, Lawrence, Lowell, Brockton, Fall River, Holyoke, and Lynn. Decreases occurred in Springfield, and in New Bedford. The top ten cities in births to teenagers totals 3526, or 50.6% of all teen births in 1985.

A list of the top 25 cities and towns in Massachusetts in teen births of all ages, and the percent of these teen births for each city and town to total births is in Table 2 for 1984 and 1985.

The top twelve cities and towns in Massachusetts in 1984 in the percent of teen births to total births for that city or town are:*

Winchendon	(25-110)	22.7%
Warren	(12-53)	22.6%
Springfield	(504-2612)	19.2%
Lawrence	(246-1303)	18.8%
Holyoke	(141-749)	18.8%
Southbridge	(44-250)	17.6%
Fall River	(234-1380)	16.9%
Spencer	(27-167)	16.1%
North Adams	(39-244)	15.9%
Wareham	(39-245)	15.9%
New Bedford	(232-1473)	15.7%
Northbridge	(29-195)	14.8%

In 1985, the top twelve cities and towns in Massachusetts in the percent of teen births to total births for that city or town were:

Holyoke	188	teen births	23.3% teen births to total births
Orange	22		21.0
Lawrence	273		18.0
Fall River	240		17.5
Winchendon	23		17.2
Athol	27		16.7
N. Adams	36		16.6
Southbridge	43		16.6
Springfield	418		15.8
New Bedford	223		15.0
Fitchburg	100		15.0
Lowell	261		14.9

* The figures on the left side of the parentheses are the numbers of teen births; figures on the right side are the number of total births of all ages in that city or town.

Winchendon dropped from first place in 1984, to fifth place in 1985, replaced by Holyoke. Lawrence moved up one place, and Orange, Athol, New Bedford, Lowell, and Fitchburg appear on the 1985 list, and were not listed for 1984. Warren, Spencer, and Wareham were not on the list for 1985.

The top 25 cities and towns, taken together in totals of all teen births, comprise 64% of all teen births in Massachusetts in 1985. In Section 7 of this report there is a breakdown of cities and towns in Massachusetts, by Health Service Area, which states the numbers of births, and percent of teen births to total births for each city and town. These lists give numbers of teen births by school age, 12-17, and for older teens, ages 18-19.

The following list states the number of teen births, and the teen birthrate for the highest 20 cities and towns in Massachusetts in 1985:

City, Town	#teen births, 12-19	Birthrate
Lawrence	273	68.0 per 1,000
Holyoke	188	59.4
Chelsea	69	41.6
Fall River	240	40.0
Lowell	261	39.1
Springfield	418	38.4
New Bedford	223	35.3
Lynn	173	34.2
Brockton	242	34.1
Boston	1,192	30.6
Fitchburg	100	29.4
Worcester	316	27.9
Taunton	77	25.4
Haverhill	83	25.3
Attleboro	57	23.4
Pittsfield	69	18.9
Somerville	85	16.8
Chicopee	62	16.3
Cambridge	68	13.1
Quincy	57	10.5

*Leominster had 62 births, but population and birthrate data were unavailable.

Profile of Pregnant and Parenting Teenagers

Who are the young mothers and their children behind these statistics? It has been consistently documented that teenagers with low self-esteem, low school achievement, and low aspirations, and those from poor and disadvantaged socioeconomic levels are more likely to become pregnant, and to become young mothers. Many live in poverty, experience family problems, and a sense of alienation. Many feel a sense of fatalism and passivity, and think that life offers them few options and opportunities, apart from getting pregnant. This is especially prevalent among adolescents living in poor homes. Many young women per-

ceive that for themselves living trapped in poverty, life offers few realities that are attainable, or that they can aspire to, apart from having a child. Giving birth, for many teens, is viewed as a "way out", or as something to give them a sense of fulfillment that is lacking in the rest of their lives.

A study states, "A very high proportion of unintended childbearing occurs to young women from economically and socially deprived families; the birth of the baby may result in negative consequences for the mother, father, grandparents, and the child itself. Many of these consequences are related to the social circumstances of the family rather than to maternal age per se."[16]

The same research study states that the psychosocial characteristics of some teenage mothers are similar to the characteristics of other "problem groups" such as school drop-outs, unemployed youth, functionally delayed youth, and delinquents. The study concludes that "solutions to the problem of teenage childbearing may be interwoven with solutions to the devastating array of problems confronting disadvantaged families."[17]

* In a research article by Joy Dryfoos, "Review of Interventions in the Field of Prevention of Adolescent Pregnancy" (1985), is stated, "teenage childbearing is, for many youngsters, a symptom of an even larger and more complex problem, namely deprivation, and that there is no way the symptom will disappear without attention to the quality of life that is producing early maternity. Though some childbearing is unplanned, the motivation to prevent pregnancy is lacking, and conception is viewed with passivity, and acceptance of 'fate'"[18] The author cites several sources of deprivation: racism, urban decay, automation, family disorganization, welfare policies, illiteracy, housing patterns, and other complex factors.

There is a continuum of needs and motivational factors that have been cited consistently from research in this area. All of these factors are amenable to change, some more than others, and all can be viewed as points of intervention in framing and implementing plans for programming and service delivery.

Beth, 17, 2 children: "I wish I could have a good place to live, lots of love, and my children to be safe....a better life than me."

For some teens, childbirth is perceived as an attempt to gain some independence from their families. For others, it is felt that having a child will give them a sense of being needed and loved. For still others, childbearing is seen as a validation of an adult role. Many are immature and inexperienced, which affects their thinking processes. Some teens lack the abilities to accurately assess themselves and their environment, to plan ahead, to anticipate the consequences of their actions, or to develop realistic expectations. Teens are generally thought of as being "risk-takers", and as entering their life experiences on a trial and error basis. Young teens, and even older teens, vascillate between seeking independence, and in needing some forms of dependence. Their behavior tends to fluctuate widely, and they are constantly striving for identification and self-esteem. A more in-depth analysis of teenage attitudes, motives, and behaviors regarding teenage pregnancy, is stated in Table 3.

The following tables are excerpted from Preventing Teenage Pregnancy: A Public Policy Guide, by Susan E. Foster, put out by the Council of State Policy and Planning Agencies, 1986, Appendix 7.

FACTORS ASSOCIATED WITH DECISION-MAKING ABOUT TEENAGE PARENTHOOD

Factors Associated With Decision Making	Decision to Become Sexually Active	Decision to Use Contraceptives	Decision to Deliver Rather Than Abort	Decision to Place Rather than Parent
DEMOGRAPHIC FACTORS:	• OLDER AGE • BLACK AT YOUNGER AGE • METRO RESIDENCE • POVERTY • LOWER EDUCATIONAL ATTAINMENT OF FEMALE • MALE	• WHITE • HIGHER INCOME • SMALLER FAMILIES • HIGHER PARITY • BETTER OCCUPATION OF FATHER • BLACK - SOONER AFTER INITIATION OF SEXUAL ACTIVITY	• OLDER AGE • MEXICAN-AMERIAN • HIGH SCHOOL DROPOUT • POVERTY • LOW PARITY	• OLDER AGE • RESIDE IN SMALL CITIES & TOWNS • HIGHER SES

FACTORS ASSOCIATED WITH DECISION-MAKING ABOUT TEENAGE PARENTHOOD

Factors Associated w/ Decision Making	Decision to Become Sexually Active	Decision to Use Contraceptives	Decision to Deliver Rather Than Abort	Decision to Place Rather than Parent
INDIVIDUAL FACTORS:	• Value and Expect Independence More and Achievement Less • Lower School Grade Average • Better Self-Esteem for Males • Lower Personal Aspirations • Unresolved Gender Role Identity • Lower Religiousity • Alcohol and Marijuana Use • No Sex Education • Traditional View of Sex Roles	• Belief in Pregnancy Risk & Safety of Pill • Sex Education • Acceptability of Abortion • Older Age at First Intercourse • Availability of Family Planning without Parental Consent • In School or Working • High Ego Development • Knowledge of Sex and Contraception • High Self-Concept • High Sense of Individual Control • Contraception at First Intercourse • Birth Control Convenient • High Educational Aspirations • More Informed Attitudes Toward Sex • Acceptance of Sexuality • Non-traditional View of Female Role	• Greater Religiousity • Conservative RE Abortion • Interest In Baby-Sitting • Desired Pregnancy • Poorer School Performance • Anxiety and Sleep Disturbance • Lower Confidence • Lower Educational and Occupational Aspirations • Lower Ego Development • Poorly Developed Future Perspective • External Locus of Control • Traditional View of Sex Roles • Passivity • Lack of Contraception	• Higher Level of Functioning • More Traditional View Re Abortion and Family • More Educated • In School

FACTORS ASSOCIATED WITH DECISION-MAKING ABOUT TEENAGE PARENTHOOD

Factors Associated With Decision Making	Decision to Become Sexually Active	Decision to Use Contraceptives	Decision to Deliver Rather Than Abort	Decision to Place Rather than Parent
COUPLE RELATED FACTORS:	• Susceptibility to Pressure from Boyfriends • A committed intimate Relationship • Couple Identity • Sense of Ability to Influence the Sexual Relationship • Lack of Ability to Communicate	• Partner Less Influential • Ability to Discuss Birth Control • Committed Relationship • Regular Sexual Intercourse • Boyfriend perceived as in favor of contraception • Sense of Power and Influence in Relationship	• Partner Not In School • Longer More Stable Relationship with Boyfriend • Partner Most Influential	• Shorter Relationship with Father of Baby • Less Influence from Partner

FACTORS ASSOCIATED WITH DECISION-MAKING ABOUT TEENAGE PARENTHOOD

Factors Associated With Decision Making	Decision to Become Sexually Active	Decision to Use Contraceptives	Decision to Deliver Rather Than Abort	Decision to Place Rather than Parent
FAMILY FACTORS:	• ONE-PARENT HOUSEHOLD • SISTER AS ROLE MODEL • LESS SUPERVISION OF DATING BEHAVIOR • VIEWS CLOSER TO PEERS THAN PARENTS • LESS INVOLVED PARENTS • WORKING MOTHERS	• WORKING MOTHERS • BETTER RELATIONSHIP WITH MOTHER • KNOWLEDGE OF SIBLING AND PARENT BIRTH CONTROL EXPERIENCE	• PARTNER MOST INFLUENTIAL IF DELIVERING • MOTHER MOST INFLUENTIAL IF ABORTING • SIBLING ROLE MODEL • ONE PARENT FAMILIES • LARGER FAMILIES	• RELATIONSHIP WITH PARENTS MEETS NEEDS • PARENTS MOST INFLUENTIAL • INTACT HOMES

FACTORS ASSOCIATED WITH DECISION-MAKING ABOUT TEENAGE PARENTHOOD

Factors Associated With Decision Making	Decision to Become Sexually Active	Decision to Use Contraceptives	Decision to Deliver Rather Than Abort	Decision to Place Rather than Parent
PEER FACTORS:	• HIGHER PEER INVOLVEMENT • PEERS AS ROLE MODELS	• PEERS LESS INFLUENTIAL • VIEWS NOT RESEMBLING PEERS	• PEERS AS ROLE MODELS	

FACTORS ASSOCIATED WITH DECISION-MAKING ABOUT TEENAGE PARENTHOOD

Factors Associated With Decision Making	Decision to Become Sexually Active	Decision to Use Contraceptives	Decision to Deliver Rather Than Abort	Decision to Place Rather than Parent
FACTORS NOT ASSOCIATED:	• YOUNGER AGE AT MENARCHE • AFDC • POPULARITY • SEX EDUCATION	• CURRENT AGE	• RACE • AGE AT MENARCHE • RELATIONSHIP WITH FATHER • EGO RESILIENCE • GIRLFRIENDS' ADVICE	• PSYCHOPATHOLOGY

Research states that most teenagers are neither emotionally nor economically prepared to assume the responsibilities of pregnancy and parenthood. As a consequence, they are often unable to cope with the pressures of childbearing and early parenting. For many young women who become pregnant, there may be a history of feeling deprived and neglected; many have been abused as children, and many are still being abused. For others having a child may be an attempt to get their own security and nurturing needs met. For still others, high school may seem pointless and removed from their own realities, and is not seen as a first step towards self-sufficiency, nor as something in which they can succeed, and that is within reach. Also, from an early age, school may have been a negative experience for many teens.

Impact of Poverty

The restrictions and limitations imposed by the constraints and far-reaching consequences of poverty are adversely affecting the lives of countless numbers of children and adolescents. The conditions of poverty, and its consequent negative human, social, personal, economic, educational, and health effects, have created enormous barriers to self-motivation, independence, achievement, and the normal progression from childhood and adolescence through to adulthood.

While poverty is not the single contributing factor to the difficulties affecting teenagers, it's negative impact is immeasurable. Teenagers perceive themselves as unable to reach for, and attain goals that others strive for and achieve. They feel their options, choices, and opportunities are limited, and their view of the world and of society is often narrow and unfocused. Other teens feel unloved and uncared for; still others have been physically and sexually abused.

> Jack, 18, one child a year old: "I want him to be successful, I want him to be happy...I can't do it all alone."

For the children and teens of recently arrived non-English speaking parents, school absenteeism may be higher, since the teen frequently needs to help his or her parents in negotiating the welfare system, and other services, or needs to get a job.

For those teenagers living in conditions of poverty, for those coming from families struggling to survive , for those in families involved in conflict, and for those whose lives are spent in chaotic environments, or for those teens who are on their own, the choices open to them, or perceived as the only ones open to them, are often dominated by the need for nurturance and sustinence, and a lack of self-esteem. These choices often destine the teenager to a further cycle of complex problems and difficulties, and do not bring the sense of fulfillment that more positive choices would have brought.

Many research studies have shown that teenage women who become pregnant do not do so in order to get handouts, or to become dependent on public assistance. Nor do they become pregnant in order to move away from home, and "get a place of their own" at public expense. These motivating factors are often attributed to pregnant and parenting teenagers, and have been repeatedly refuted in research literature. Many young women become pregnant unintentionally. Many others feel that having a child is a viable option to what their lives are, while others see having a child as the only option left open to them. Young teen males and females often lack the adequate and accurate information regarding sexuality and conception.

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In both rural and urban areas young women perceive a definate lack of opportunities in their lives, and an absence of motivating alternatives to childbearing. They feel "locked into their stations in life".[19] Some needy women think that having a baby will fill a void in their lives, and help them to feel a sense of direction and purpose. They often have a sense of hopelessness and resignation, and do not perceive that they may be placing their infants and children at risk for a repeat of the same pattern as their own lives. Many become pregnant again within a short period of time after the first birth. Many have hopes of escaping a dreary existence. Instead, these teens may sink into heavy responsibilities and demands for which they are unprepared. For many, their lives become out of control, and they often become entrenched in a generational cycle of poverty.

Service Delivery

While agencies and service providers are involved in servicing the needs of pregnant and parenting teenagers with solid, positive programming in many areas, some agencies tend to treat the problems and individuals experiencing these problems in isolation, and on a single-service basis. Schools deal with educational problems, medical facilities deal with problems of a health nature, and so on. Many teens who become parents have multiple problems themselves. Many also come from multiproblem families.

Investing in resources to develop comprehensive and integrated servicing systems is a critical and essential framework for addressing the complex needs of this population of adolescents.

According to research findings from "Private Crisis, Public Cost",[20] regarding motivational and other factors with teenagers, "while a service provider, policy-maker, or research team may select only one of a few factors for concern, it should always be kept in mind that these factors represent part of a complex process with numerous determinants operating consecutively or simultaneously, together or in opposition, helpfully or harmfully, rationally or irrationally, among some individuals but not others, and that some are far harder to change than others."

Janet, 15, one child: "I want to get off welfare, have a nice place to live, and someone to take care of me and the baby."

Each contributing factor, each motivational determinant of behavior, each area of experience and level of maturational development, and the problems and disruptions causing interferences, can be viewed on a continuum of points at which intervention and prevention approaches are crucially needed.

The Women's Legislative Caucus Task Force on Pregnant and Parenting Teenagers, under the direction of Chairperson, Representative Patricia G. Fiero, recently sent over 1500 questionaires to the agencies and service providers who service pregnant and parenting teens in Massachusetts. The teenagers they see in their facilities were asked to fill out the questionaires. The purpose of these surveys was to obtain an informal profile and determination of needs from the teenagers themselves, and to ask for their recommendations based on personal experiences. Questions pertained to areas such as age of the adolescent mothers,

ages of the fathers, educational attainment of mother and father, reasons for leaving school, number of children, living arrangements and source of income of mother, employment status of mother and father, what they perceive as their needs, what they would like to see for the future for themselves and their children. Questions were also asked in other areas that will be discussed later in this report.

Preliminary findings from the first returns of the questionaires from teen mothers and a few fathers confirm some of the life experiences found in the profiles of this population. Many of the responses represented needs of nurturance, loneliness, feelings of isolation, and expressions of "wanting a better life for my child than I have". Mixed in with the practical needs stated by the teens are emotional needs as expressed in statements such as "housing, money, and lots of love," "money, a place to live, and someone to care for me and my baby". When reasons were given for leaving home, or dropping out of school, many teenagers, both mothers and fathers, stated that the reasons were often related to complex family problems. Statements such as "got kicked out of the house", "left because of family problems", "couldn't live at home", were frequently made in the responses to the questions.

Other preliminary findings are stated throughout this report. The quotes found in the report are statements made by teen parents on the questionaires. A full report of the findings and conclusions from the questionaires will be forthcoming from the Task Force.

Fathers of the Children of Teenage Mothers

There has been a long-term lack of information about, and studies done with, the fathers of infants and children born to teenage mothers. Some literature refers to these fathers as the "missing father myth",[21] meaning that there is an assumption, often incorrect, that these fathers are not present after the birth of the child, or during pregnancy, and are not generally part of the lives of the mother and child. Some recent studies have shown that frequently this is not the case. Young fathers, or older fathers, often do want to contribute financially and with support, and do want to take some of the responsibility, and to be part of the life of the child or children. In some cases, the family of the father may become involved, and the mother may then live with his family.

Some fathers do become alienated from the mother, the child, and the family of the mother; many are only marginally in the lives of the mother and child. But many are available, and do contribute what they can. Many of the young fathers also drop out of school, and work in underpaying jobs, or become unemployed themselves. The age, economic and educational status of many of the fathers often precludes the feasibility of marriage. Most do not have the resources, emotionally, socially, or financially, to help in any substantial ways, but do make some attempts.

Research indicates that many fathers usually do not marry the teen mother, but often continue to date her through the baby's first years. Many fathers do want to help support both mother and child, and want to contribute as best they can, and according to their own abilities. In one study conducted by the Department of Human Services at the University of North Carolina, findings from a survey of 26 male parents between 16 and 21 years, stated that 22 believed they had responsibilities towards the mother and baby, and 18 of the fathers saw the mother and child at least once a week.

The fathers of the babies of teen mothers, whether they are themselves teenagers, or are older men, sometimes face hostility from the mother's family. Young

fathers are often left out of decisions that are made about their babies, mostly by the mother and her parents. Often, fathers are not even told when the baby is born, or that the child has been placed for adoption or for foster care placement.

While many young fathers may be eager to help and contribute during the first few months, or even years of the baby's life, gradually they become overwhelmed by the unexpected medical, clothing, food, and other needs, and their financial contributions cease or dwindle to a small amount.

Research indicates that many young men go through the same emotional struggles and confusions as the young mothers do, and are experiencing the same difficulties within themselves. Young fathers have many of the same needs as the young mothers do. Teenage fathers, or older men who father the children of teen mothers, often want the babies as much as the mothers do, for many of the same reasons. For both, having a child may seem to be something in their lives that is truly theirs. Since many of these parents do poorly in school, and in other aspects of their lives, having a child is an accomplishment. For many who come from troubled homes, a baby can be viewed as the first human from whom they can receive love.

Ages of Fathers

There are recent studies indicating that many fathers - some estimates are as high as 50% - of the babies of teen mothers are not themselves teenagers. Some studies indicate that often the fathers are several years older than the teen mothers. This is an area of current research, and one that must be carefully considered for it's implications and impact.

Preliminary findings from a sample of 250 questionaires with pregnant and parenting teens, by the Task Force, indicate that 45%-55% of the fathers are older men, some by several years. The age range varies, with some fathers 3 to 4 years older than the teen mothers, ranging upwards to 8-10 years older. Many fathers are in their early, mid, and late twenties; a few are in their 30's and 40's. While no conclusions may be yet drawn from this data, a thorough analysis of this area is essential in preventive intervention programming plans, and in determination of motivational factors. There is no way of determining if the present child or children of these older fathers is their first, or second, or if they have fathered other children in the past. There are some teen mothers who have several children by different fathers. Research is much needed in this area, especially in the areas of the specific, perhaps unique relationship between a teenager who is pregnant and/or a parent, and an older father, and in determining whether or not older men who are fathers have fathered any children when they themselves were teenagers.

Clearly, prevention and intervention strategies must incorporate sound strategies targeted at young male teens, with regard to first pregnancies prevention, and with repeat pregnancy prevention approaches, along with essential programming components geared towards responsible behavior on the part of teen males.

Relationships of Teen Mothers and Fathers

From preliminary findings of the responses of the teenagers on the questionaires, regarding the "missing father myth", while it is not possible to determine

to what extent, many fathers do seem to be part of the life of the teen mother and child or children, to some degree or other. Some of this seems to be by implication only, other by direct references. For example, in response to the question on the survey, "What would you like to see for the future for you and your child/children?", many mothers answered, "To be able to live with my baby and the father and be happy", "To marry the father of the baby, that we will finish school, and that he will get a good job." Many teen mothers, when asked questions about the educational status, and job status of the father, knew these facts exactly, such as that the father is presently in a G.E.D. program, that the father works 40 hours a week, where he works, and that he works at night, or during the day. Most know the year the father left school, if he has left school. These responses would seem to indicate that many of the teen mothers had current knowledge about the lives of the fathers. Many of the mothers also knew why the fathers dropped out of school. Many reasons for dropping out were seemingly unrelated to pregnancy or parenthood. Findings in this area will be discussed further in the section on education.

The Children of Teen Mothers

There is some research that indicates that teen mothers may have more children than older mothers. Other research indicates that teen mothers may have a few, or several, children while they are younger, but the numbers of children tapers off, as the mothers get older. Therefore, teen mothers may have somewhat more children than older mothers, but they may also have the same numbers of children as do older women, but at younger ages.[22]

There are currently 1.4 million children now living with teenage mothers, 50%-60% of whom are unmarried.[23] An additional 1.6 million children under age 5 are living with mothers who were teenagers when they gave birth. About 82% of teenage women who gave birth at age 16 years and younger were daughters of teenage mothers.[24]

In Massachusetts in 1984, 1,126, or 16%, were repeat births to teen mothers of the 2nd, 3rd, 4th, and 5th child. In 1985, 1,131, or 16.2% were repeat births of the 2nd and 3rd child.

The children of teen mothers are often at risk of having developmental disabilities, learning problems, and mental and physical difficulties. While the children of poor mothers of any age may experience these problems, they may be exacerbated in the children of teen mothers. There is a growing body of research addressing the health, developmental consequences, and effects of poverty on early pregnancy and childbearing, and on the children of teenagers.

The National Research Council issued it's report, Risking the Future: Adolescent Sexuality, Pregnancy and Childbearing. The panel was composed of professionals and concerned citizens with divergent viewpoints, who studied all aspects of these issues for two years. Findings indicate that "these children face increased risks for their own life outcomes, including cognitive development, health status and health behavior, educational attainment, sexual and fertility behavior."[25] The report states factors that need further study, and asks, "To what extent can various forms of family support, parenting education, public income transfers, pediatric health care and child care, and child development assistance mediate these likely negative outcomes?"[26]

Frequently, teen parents are unable to adequately nurture their children, and need support systems that are often extensive. Also, "children of teens tend to have lower IQ's (also due to other factors such as poverty and deprivation) and school achievement scores, and are more likely to repeat at least one grade. The cycle of family instability is often established."[27] Children who live below the poverty line, as many teenagers' children do, are more than twice as likely to be chronically undernourished as the general population. Health costs for undernourished children tend to be higher throughout their lives. These children are often at-risk for living in poverty much or most of their lives, and may even perpetuate this generational cycle themselves, if options, opportunities, and substantial support systems are not made available to them early in their lives. These children will also have a vulnerability to becoming teen parents themselves. According to research studies in the report from the National Research Council, "What limited evidence there is shows that the age of the mother at the birth of the child, affects the child's intelligence, affects academic achievement, and can cause retention in school grades." The study points out that these effects are consistent for blacks and whites, boys and girls.[28] Several studies state that these consequences are also greatly influenced by poverty, the inability of many teen parents to adequately stimulate and nurture their children, and other factors.

Research studies cited in this report consistently point to the relationships between the mother's school completion and attitudes towards education, and those of her children. One study[29] reports that children born to mothers who had fallen behind or dropped out of school before their first pregnancy had poorer cognitive performance than children born to mothers who were in school or on grade when they became pregnant or who continued school after their first child was born. The report states, "The cycle of school failure, frustration, and disinterest among the children of adolescent mothers is of great concern, because we know that it is strongly associated with early sexual activity and pregnancy in girls and with antisocial behavior in boys. For both sexes it bodes ill for future educational attainment, marital stability, employment and income, and later socioeconomic well-being."[30]

Maria, 16, 1 child: "I want to have a close relationship with my baby and the father, and to marry one day. I wish I could give everything to the baby that he needs."

More research is needed on the educational status of teen mothers, fathers, and their children. Some available research is cited in the section on education.

Beginning results of the questionaires from pregnant and parenting teenagers indicate a serious concern on the part of the mothers for the health and well-being of their children. Statements such as, "I want my baby to be healthy and happy and safe", or, "I want my baby to have a nice place to live, lots of love, and an education" appear regularly throughout the questionaires. Further analysis of these results will be forthcoming from the Task Force.

Family Factors

The National Research Council conducted a search on studies that had been done on family factors and influences. The panel conducting the study felt that there is "an implicit assumption that teens are solely responsible for creating

problems of adolescent pregnancy and for coping with the consequences. Research examining the roles of families, and the roles of individual family members is limited."[31] The report cites the fact that most studies that do exist focus on the mother-daughter relationship, while the role of fathers, and the relationships of the parents to sons and siblings is largely ignored. More research is needed in the areas of the roles of family members, and the extended family, on adolescent sexual decisionmaking among boys and girls, and motivational factors, influenced by family structure and parental involvement as to life planning, educational interest, career exploration, and other factors at all stages in the sequence of choices.

Information that does exist indicates that "For an adolescent girl who becomes a mother, it appears that the attitudes and actions of her family of origin can significantly affect decisions concerning the management of her life and that of her child - where she will live before and after the pregnancy, her continuation of school, labor force participation, child care, and her relationship with the baby's father. Available research states that teen mothers who remain in their families of origin during pregnancy and for a defined period thereafter are likely to receive substantial financial and child care support, and that this support has definite short-term positive effects for mother and child."[32] However, family factors that appear to affect the level and quality of parental support and controls are family intactness, family composition, and the mother's age at marriage.

Research indicates that longitudinal studies are needed to illuminate the support and coping processes of young teens. Studies are needed that can identify the long-term consequences for various family members of providing family assistance to a teenage mother. The role of the families of young fathers also needs study. A more complete discussion of influencing factors and determinants of behavior is found in Section 5.

The remainder of updated findings from Part 1 will be presented at the beginning of the sections of this report.

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Programs and services to intervene and improve the life experiences and life options of pregnant and parenting teenagers and their children, and to prevent teenage pregnancy, have been developed and expanded continuously since the early 1970's in the United States. Frequently, these programs, in various formats, have stirred up debates and controversy among advocates and opponents - either over entire programs, or particular components of programs. Public, private, voluntary, and philanthropic organizations have pursued solutions to the various issues, needs, and consequences of teenage pregnancy and early parenthood.

During the 1970's and 1980's, an increasing number of programs serving young parents and pregnant teens were established under various umbrellas - community-based organizations, youth servicing agencies, schools, hospitals, and various other groups and agencies. "While many of these programs began with a focus on one or two specified problems - for example, retaining pregnant teens in school settings, or providing prenatal and postnatal health care, programs increasingly recognized the need to offer comprehensive services. The movement gained momentum bacause of a growing awareness that programs in the early 1970's were inadequate because those that existed were neither efficient nor effective in delivering the wide range of services needed. The fragmentation of effort and lack of coordination were continuously cited as obstacles to successful service delivery."[33]

Free Clinics and Adolescent Medicine

During the mid- to late 1970's, there was a growing public and professional awareness that most pregnant and parenting teenagers have multiple and varied needs, and that many of the services they required were "fragmented, inefficient, and inadequate."[34] Comprehensive care programs became the preferred approach for assisting the target population, many of whom came from economically and socially disadvantaged life situations.

According to Dryfoos,[35] in the early '60's and '70's, the needs and unique problems experienced by teenagers indicated the need for medical care and counseling for this population. The response to this concern were free clinics located in areas with large concentrations of troubled youth. These clinics offered walk-in support and some medical services of "uneven quality", usually provided by a voluntary staff at no cost to the client. There was a strong orientation to promote positive health behaviors, education in nutrition, exercise, and life style changes. Only a few of these free clinics remain today. For many teenagers, family planning clinics have become the primary source of medical care. More information on family planning clinics is presented later in this report.

According to an article in the Journal of Medical Education[36] "perhaps because adolescents and young adult s have been perceived by the medical community as generally healthy, most health professionals have not received training in adolescent development and pathology. Moreover, specialized training in adolescent medicine is a relatively recent phenomenon." Although adolescent units in hospitals first opened in the 1960's, they are still quite uncommon. "And by the end of the 1970's, despite the growth of adolescent medicine divisions, few providers had received specialized training in adolescent health."[37]

Responses to Federal Reductions

In 1981, reductions in federal support for health services were proposed. As a result, the conclusions drawn were that many clinics serving youth and offering services in family planning, mental health, and sexually transmitted diseases, would close. In response to the health problems of high-risk teens and their difficulties in accessing to health care, the Robert Wood Johnson Foundation funded a $12 million national demonstration program for improving health services and health outcomes for high-risk young people. The program offers grants to 20 teaching hospitals that, in partnership with public and private agencies, are providing community-based, comprehensive services to young people between 15 and 24 years of age. The demonstration is called the Program to Consolidate Health Services for High-Risk Young People. A description of the programs, the objectives, rationale, and goals of the programs, are discussed in the Journal of Medical Education article titled, "Development of Community-Based Health Services for Adolescents at Risk for Sociomedical Problems" (Vol. 60, Oct. 1985). A further discussion of the Wood Foundation and programs it funds are contained in other sections of this report.

Comprehensive Care

Consolidation of services, reflecting the services integration concept, gained attention during the 1970's. At that time, there was a growing awareness among health providers that the federal grants process had encouraged fragmentation of health services. As a consequence, "those involved in developing the high-risk young people's programs judged that adolescents at-risk for multiple problems would be unlikely to receive care if they had to seek treatment from multiple sources. It seemed that comprehensive services delivered at a single site was a better way to assure care for this population."[38]

In 1981, the consolidation concept seemed to be the best response also to the reduction in funding for categorical services, such as family planning or maternal and child health care, which might force community clinics to either close, or cut back in their services. Thus, the Wood Foundation hoped that by offering grant support to institutions that would maintain services, their programs "sought to demonstrate that needed services could be maintained in an era of retrenchment."[39]

In the Dryfoos article, "School-Based Clinics: Serving Adolescents Where They Are", the author states that there developed a "recognition by the medical profession of the specialized needs of adolescents for a more comprehensive approach to the treatment of the physical, social, and psychological problems" of this population.[40] The American Academy of Pediatrics was very instrumental in raising these concerns.

Initiatives in Teen Pregnancy Programs

Since adolescents need to learn and know how to gain good health and how to maintain it, which behaviors to obtain and which to avoid, "the ideal system for adolescent health care would encompass both promotion of good habits and treatment of the problems. Nationally, the job of health promotion has been

carried out almost entirely outside of the medical establishment, largely in the schools, youth programs, and through the media."[41]

According to the report from the National Research Council and the Committee on Child Development Research and Public Policy, "by 1985, nearly half the states had taken steps to develop their own responses to growing public concern about these issues of teenage pregnancy and parenting. Initiatives have ranged broadly from coordinated statewide policies, to agendas for action by governors' blue ribbon task forces, to single agency programs and local isolated efforts to address the special needs of at-risk teens."[42]

There are literally hundreds of programs now in operation throughout the country. These programs typically "offer or broker through arrangements with other service providers in the community, such services as prenatal education, parenting education, nutrition education, life management skills training, educational counseling or services, family planning education, personal counseling, recreational activities, and peer support groups. Relatively few, until recently, have offered or brokered employment-related or vocational services to their clients."[43]

The past decade and a half has brought forth a vast number of policies and programs to help delay teenage pregnancies, and to reduce the negative consequences of early childbearing and parenthood. Some of these have been initiated and supported by federal grants; others have been initiated by local communities and at the state level; others have been initiated, developed, and funded by private foundations and philanthropic groups and organizations. Many are the result of public and private partnerships. Some have focused on the teenager alone; others on the father, the teen's parents, and even on the extended family and peers of the teenager. Some provide specialized services, in isolation or as part of a referral and information network; others have been broad, comprehensive, and multiservice in scope and in practice. "Programs have been organized in schools, churches, community centers, social service agencies, clinics, and hospitals. Some have been single-site programs, while others have been replicated at several sites within a city or across the nation. Despite the magnitude of human and monetary resources that have been directed at tackling the problem of adolescent pregnancy, however, there has been no systematic attempt to assess the effects and effectiveness of alternative approaches in light of growing scientific understanding of early pregnancy and parenting."[44]

The National Research Council report, Risking the Future, states, "Yet, after more than a decade of experience, there seemed to many observors an imbalance in emphasis between what people believed and what policy makers, professionals, and society in general knew about the impacts and cost-effectiveness of alternative prevention and amelioration strategies in light of better scientific knowledge about early sexual and fertility behavior. There seems to be distressingly little discussion about how various interventions work, for whom, under what circumstances, and with what intended and unintended effects. And what were the most promising directions for future policy and program development?"[45]

The Research Council points to the fact that there is a lack of a coherent approach toward policy because adolescents "are not a monolithic group, and adolescent pregnancy is not a unitary problem. For young people of different ages, living in different social, economic, and cultural circumstances, the meaning of early sexual activity, pregnancy, and childbearing is not the same."[46]

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In the 1960's and 1970's, the federal government took a more active role in initiating and financing pregnancy-related programs for teenagers. In 1967, the Child Health Act, Title V of the Social Security Act of 1935, funded maternal and child health programs that were targeted at reducing infant mortality. Through this Act, special projects grants, administered by the Bureau of Maternal and Child Health Services, were made directly available to local health departments to provide comprehensive care to children and teenagers in low income families, and to improve pregnancy outcomes through prenatal and postnatal care services.[47]

Title X of the Public Health Services Act of 1970

Under the Family Planning Services and Population Research Act, Title X of the Public Health Services Act of 1970, federal funds were allocated for family planning projects. These projects included expanded accessibility to contraceptive services for low income women, the development of improved methods of family planning personnel training, and the preparation and distribution of educational materials. These programs were beneficial to adolescents, who were a subgroup of the larger at-risk group. In 1978, Congress amended the Family Planning Services and Population Research Act to specifically require programs to provide services to adolescents.

Title X funds more than 5,000 family planning clinics operated by states, local health departments, and private non-profit groups that disseminate information and contraceptives. Under Title X, abortion counseling and referrals for abortions were permitted until recent changes prohibited this service.

Funding for Title X was not reauthorized for 1986, but was funded through continuing appropriations by a resolution, at the level of the 1985 amount of $142.5 million.

Title X is currently the largest federal initiative addressing the problem of adolescent pregnancy. In 1983, the program served 4.5 million individuals, more than a third of whom were under age 20. The legislation encourages, but does not require, parental notification for minor teenagers to receive contraceptive services.[48] Contraceptive services are available to teenagers through several other federal programs, including maternal and child health and social services programs that were made block grants in 1981, and also through Medicaid.

Office of Adolescent Pregnancy Programs (OAPP)

In 1978, the Federal Office of Adolescent Pregnancy Programs was established in the Public Health Service to administer the Adolescent Pregnancy Prevention and Care Program. All programs concerned with adolescent pregnancy and childbearing were to be coordinated with programs in the U.S. Department of Health Education and Welfare.

The original legislation, PL 95-625, was changed to PL 95-626. Programs funded under this legislation, as defined in the Act, must provide "core services" which include comprehensive health care, social services, counseling and other services, either directly or by referral. Additional services, beyond the core group of services, can be provided at the option of service providers.

After less than three years, during which 38 local projects received grants, the program was dismantled. The appropriation was folded into the Maternal and Child Health Block Grant in 1981.

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The Urban Institute evaluated 28 programs funded under this Act during 1982 and 1983. The outcomes of program participants were compared with national standards, but no control groups were used. Overall the OAPP participants were more likely to be in school, or to have completed school, than were young parents nationally. This finding was especially true for those participants who had entered the programs during pregnancy, as opposed to those who entered after the birth of their child. For those who participated in two years of services, rather than only one year, outcomes improved even more.

The major thrust of this legislation and the resulting programs, was directed towards secondary prevention, despite the growing concern about teen sexual activity, and early pregnancy and childbearing among teenagers, and the need for primary prevention programming. This secondary prevention was defined as the alleviation of the negative consequences of pregnancy for the parents and their children. States were not encouraged or expected to be actively involved. Funds and technical assistance were to flow directly from the federal to the local level, and, in many cases, private organizations.[49]

The Adolescent Health Services and Pregnancy Prevention and Care Act of 1978, Title VI of the Health Services and Centers Amendments Act, was the first federal legislation initiated to focus solely on the problems of early sexuality and teenage pregnancy.

Title XX, Adolescent Family Life Act (AFL)

In 1981, the Omnibus Reconciliation Act repealed OAPP, replacing it with Title XX, in which Congress enacted a new categorical program concerned with adolescent pregnancy. This Act represents an explicit acknowledgement by Congress that the federal government should address the problems of increasing adolescent sexual activity, pregnancy, and childbirth. The legislation made a distinction between services for which only pregnant and parenting adults are eligible (secondary) and prevention services which are aimed at preventing adolescent sexual relations (primary), and are available to any adolescent.[50] The legislation created attention when it promoted adoption as an alternative for adolescent parents.

The Adolescent Family Life Act is administered by the Office of Adolescent Pregnancy Programs within the Office of Population Affairs. According to a report, "The Adolescent Family Life Demonstration Projects: Program and Evaluation Summaries,"[51] its mission is "to address the problems associated with adolescent pregnancy by funding demonstration and research projects and to disseminate its findings for use at the state and local levels." The objectives of the AFL programs are "to promote positive, family-centered approaches to the problem of adolescent premarital sexual relations, including adolescent pregnancy; to promote adoption as an alternative for adolescent parents; and to establish innovative, comprehensive and integrated approaches to the delivery of care services for pregnant adolescents with primary emphasis on unmarried adolescents who are 17 years of age and under, and for adolescent parents."[52]

Since 1982, the Office of Adolescent Pregnancy Programs has supported studies of familial, institutional, and societal influences on early sexual behavior and adoption, as well as the provision of services to pregnant and parenting teens.

Legislative authority for the AFL Program was renewed for a year in 1984, and expired in 1985. In 1986, it operated under a continuing resolution. Currently,

the Civil Liberties Union is bringing suit on grounds of entanglement of church and state in the administration of the program. Title X and Title XX are separate, though linked in recent legislative deliberations. The U.S. House supports and is strongly interested in the reauthorization of Title X, and the Senate appears to be more committed to continued support of Title XX.

The AFL Act places more emphasis on the prevention of early sexual activity, and less emphasis on the provision of contraceptive services, while retaining the previous program's commitment to providing care for pregnant and parenting teens. The prevention focus is primarily on "the promotion of abstinence from premarital sexual activity through the development of strong family values."Contraceptive services to adolescents are not a major component of the program, since originators of the legislation presumed that such services are adequately provided under Title X. Program funds may not be used for abortion, or abortion counseling.[53]

The legislation authorizes support for research and demonstration projects rather than for permanent programs. The intent of this is to stimulate the development of innovative approaches that state and local, public and private, funding sources can sustain. The legislation also specified that all demonstration programs include rigorous evaluation, but adequate funding for this component was not provided.

Components of AFL Programs

Three major components are emphasized in the AFL programs: Research, Demonstration, and Evaluation:

Research: To date, AFL has provided support for 33 research projects dealing with various aspects of adolescent pregnancy including the determinants and consequences of premarital sexual activity, decisionmaking for the resolution of teen pregnancy, the effects of care services on pregnancy outcome, and the subsequent development of the adolescent and her infant.[54]

Demonstration: These projects provide care services for pregnant and parenting teenagers and their families, prevention services to encourage adolescents to postpone sexual activity, or a combination of both. As of January, 1986, AFL supported 79 demonstration projects, with sites in 45 states, Puerto Rico, and Guam. Projects may be based in schools, hospitals, or other health or social services agencies, in both rural and urban communities. Services may be delivered by a single provider at one site, by a single provider at multiple sites, or by a network of providers at one or more sites. "By systematically varying these significant project components, AFL is supporting the development of models which, if evaluated as successful, can be disseminated to similar localities for replication."[55]

Evaluation: Each demonstration project has an internal evaluation component designed to test hypotheses specific to that project's service delivery model. Projects are evaluated by an independent evaluator contracted by each grantee. Evaluators are usually affiliated with a college or university in the grantee's state.[56]

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In January, 1986, the Office of Population Affairs in Washington, D.C., published a report giving summaries of programs and evaluations around the country.[57] Descriptions are presented in the Guide on 66 demonstration projects. An additional 17 sites have recently been funded, but have not been in operation long enough to be included in the summaries. Their names and addresses are in the Appendix to the report. Project summaries are stated according to the kind of services provided: care, prevention, or a combination of both.

Care service programs are required to provide directly or through referral, ten core services:[58]

pregnancy testing and maternity counseling
adoption counseling and referral services
primary preventive health services including prenatal and postnatal care
nutrition information and counseling
referral for screening and treatment of venereal disease
referral to appropriate pediatric care
educational services relating to family life and problems associated with adolescent premarital sexual relations
education and vocational services
counseling and referral for family planning services
referral to other appropriate health services

In addition to the ten core services, certain supplemental services are eligible for funding:

child care
consumer education and homemaking
counseling for extended family members
transportation
outreach services for families of adolescents to discourage sexual relations among unemancipated minors

Each program summary in the Guide is divided into five sections: Directory/Reference, Program Description, Demonstration/Evaluation Design, Outcome Data/Measures, and Preliminary Results.

In 1982, Adolescent Family Life Programs were established at St. Margaret's Hospital in Dorchester, and at the County Adolescent Network of Berkshire, in Pittsfield, Massachusetts.

The program at St. Margaret's Hospital is called the Adolescent Family Life Project, and is a Care and Prevention Project, serving a racially mixed population, the majority of whom are white. The model is described as a "maternity home and out-patient project sponsored by a private hospital." The number of clients served from 1984 to 1985 is as follows:

Care:	pregnant adolescents	292
	adolescent mothers	205
	infants	112
	male partners	194
	extended family members	239
Prevention:	youth	2755
	adults	671

Program Description: Pregnant adolescents may live in the maternity home at St. Margaret's, or commute to the program each day. Those who have not yet completed high school may attend the program's on-site alternative school. All teenagers attend a Decision-Making Group that is concerned with choices about keeping the baby, or placing the baby for adoption. Counseling services are offered to family members and male partners, as well as the young women. High-risk mothers are followed in home visits after delivery, and other clients may be followed in an out-patient Pediatric Clinic at the hospital. Infants are tested using the Denver Developmental Inventory.

The prevention component of the project offers a Family Life Education curriculum to students in grades seven through ten, their parents, and their teachers in schools and community agencies. The course is offered in both English and Spanish. The program also offers an Asian Family Life Project.

The care and prevention components at St. Margaret's serve a racially-mixed population.

Findings from a 1983-1984 evaluation measuring the impact of the Decision-Making Group on clients indicated that there are two variables that are correlated with making an adoption plan: mother's favorable attitude toward adoption, and client's lack of familiarity with peers who chose to parent. Eighty-seven percent of the group's participants found the group helpful, and 17 percent made a final adoption plan.[59]

Programs listed in the Guide under Newly Funded Projects included a program in West Springfield, Massachusetts, Our Lady of Providence Childrens' Center, Inc.

The Guide did not have a program summary and evaluation for the County Adolescent Network of Berkshire, in Pittsfield, Massachusetts.

Legislative Initiatives

While the current Administration, Congress, national and local groups, states, and the public now recognize teen pregnancy as a national problem, there is no consensus on how to attack the problem.

According to Representative George Miller, D-California, who chairs the Select Committee on Children, Youth, and Families, there has been increased awareness of, and impact on, the members of Congress about the magnitude of the problem. Increasingly, questions are asked about what the root of the problem is, and why the problem has persisted, despite government attempts to confront and solve the problem.

A recent article on teenage pregnancy states, "Like the broader issue of poverty, in which it is deeply enmeshed, teen pregnancy elicits political differences over the role of the federal government in attacking social problems. Conservatives, who see the growing problem as a sign that government policy has accomplished little and may have actually exacerbated the problem, are sharply divided from liberals, who see it as a sign that the federal government has not done nearly enough."[60] These differences have created a stalemate and an often-heated debate that has stalled key legislative proposals designed to prevent teen pregnancy.

After surveying state efforts and finding them fragmented, the Select Committee on Children, Youth, and Families reported, "We believe we can do better by focusing much more attention on preventing unwanted teen pregnancies...we know contraception works, we know sex education can make a real contribution...

we know there are emerging prevention models, like school-based clinics, that have already shown enormous potential."[61] These conclusions were reached by the Democratics and two Republicans. However, the report had a minority opinion by six Republican members which said, "Progressively over the past 25 years, we have, as a nation, decided it is easier to give children pills than to teach them respect for sex and marriage. Today we are seeing the results of that decision not only in increased pregnancy rates, but increased rates of drug abuse, venereal disease, suicide, and other forms of self-destructive behavior..."[62]

Rep. Dan Coats, R-Ind., the committee's ranking minority member, stated, "Society's attitudes and values play a large role in the ills we face, and until we deal with these values and attitudes, we'll never get at the heart of the problem... You can't legislate attitudes."

Miller argues that existing federal programs have not gone far enough, stating, "there's no evidence that we're doing a comprehensive effort... federal programs are a hodgepodge, a patchwork, a hit-and-miss operation."

The two views diverge on policy descriptions and also disagree on what is at the root of the problem.

The Reagan Administration moved to require any recipient of federal family planning money to notify parents before dispensing contraceptives. The rule caused public outcry, and was struck down in two federal court decisions in 1983.

Conservatives have consistently linked abortion and family planning, causing confusion, conflict and near-cessation of proposed legislation and funding for programs.

School-Based Health Clinics, another initiative that has been proven to be effective in reducing teen pregnancy, have also generated controversy. In 1986, proposed legislation by Miller requested 50 million dollars to finance experiments with school-based service centers offering not only academic and job counseling, but also health services to teens, including family planning information.

Conservatives perceive the clinics as another attempt by the federal government and schools to usurp the family's role and "spread destructive messages."

Many members of Congress are optimistic that some common ground may be reached as to approaches and solutions to teen pregnancy, in light of increasing concern about teen pregnancy, and about the fact that programs, in general, that have been funded by the federal government, have in some instances been fragmented and ineffective. Formal and informal groups and task forces involving all aspects and positions regarding teen pregnancy and related issues and needs of teenagers have been formulated, and members are communicating and carrying on a dialogue in open discussions and confrontation of solutions.

In 1985, Senator Patrick Moynihan (D-N.Y.) introduced legislation that amended Part A of Title IV of the Social Security Act, known as AFDC, or Aid to Families with Dependent Children. The legislation would direct the Secretary of Health and Human Services to make grants to states to carry out programs that would prevent long-term dependency on AFDC, permit pregnant teenagers and teenage mothers to remain in school, provide job counseling, employment readiness, job placement, and academic and vocational education services to pregnant and parenting teenagers, and integrate and coordinate services otherwise available to teens. Senator Moynihan's measure was introduced also in 1986, and would be paid for by federal grants to states amounting to 2 percent of each state's budget for the AFDC program.

In 1987, Senator Moynihan filed S1511, the Family Welfare Reform Act of 1987. Many groups and advocates are concerned about certain provisions of this bill in that it contains several minor parent provisions that could be detrimental to young families. According to the Alliance for Young Families in Boston, these provisions are as follows:

1. grandparent deeming remains
2. pregnant/parenting minors would be required to live with their parents in order to qualify for benefits
3. minor parents would be required to participate in an employment and training program, regardless of the age of the infant, or the availability or appropriateness of child care

According to the Alliance, "in addition to these minor parent provisions, S1511 includes: a mandatory work/training requirement for parents with children age 3 or older, with a state option as young as one; no federally mandated minimum benefit level; no guarantee that states must provide a range of work/training programs in order to accommodate the various needs of the families on AFDC; and only a $160 a month reimbursement for child care expenses." S1511 is an extensive piece of legislation, and has been refiled for 1988. S1511 is on file in the Task Force.

Report of the General Accounting Office (GAO)

In 1986, a report released by the General Accounting Office of Congress, expressed concern about the serious social and economic consequences of the birth rate among married and unmarried teenagers. The report stated that the federal government has few programs dealing with teen pregnancy. Despite the consequences of teenage pregnancy, there is only one program specifically directed at the problem, with a budget of about $15 million. There are state and local programs spending millions of dollars on a range of prevention and care programs for pregnant and parenting teenagers. The General Accounting Office Report states that the effectiveness and possible application and impact have not been evaluated. Findings of the report of the GAO are:[63]

* Federal programs are needed in the areas of providing medical and nutritional services, educational opportunities and counseling services to pregnant and parenting teenagers.

* More than a million teenagers become pregnant each year; about one-half give birth, and one-half either have an abortion, or a miscarriage.

* The abortion rate has risen among teenagers, ages 15-19, from 23% in 1972 to 33% in 1981.

* The birth rate for teenagers has dropped from 62 per 1,000 in 1972 to 53 per 1,000 in 1981. Pregnancies are increasing.

* Unmarried teenage birthrates have increased, from 23 per 1,000 in 1972 to 30 per 1,000 in 1983. Birthrates for unmarried teens varied greatly from state to state.

* Poverty is a causative factor in teenage pregnancy among unmarried teens.

Senator John Chafee (R-Rhode Island), who requested the study, has asked for further study before Congress proposes a comprehensive approach. He called for programs that would reduce teen pregnancy, either by encouraging teens to postpone - delay sexual activity, or by disseminating adequate birth control information. Senator Chafee sponsored one of more than 20 proposals in Congress dealing with the problems of teenage pregnancy. Chafee's proposal would have cost $30 million, and would fund programs providing comprehensive care during pregnancy, and after birth, family planning, counseling, and educational opportunities.

Definition

A policy is a plan or course of action designed to influence and determine decisions and actions. It uses guiding principles in practical matters.[64] Any policy developed and implemented should incorporate all of what is known about the issue to be addressed, confronted, and resolved. Policy drives decision-making, and is formulated by needs, problems, the social, political and economic climate of the times, and from issues that surface to become the focus of politicians, administrators, public officials, community leaders, advocacy groups, and others involved with, influenced by, or concerned with, those issues confronting society.

Policies are determined by:[65]

- the problem itself
- those who come together to address the problem
- the resources available, and those that are needed
- the cultural, ethnic, religious, political and moral climate of the state, community, or group addressing the problem
- the people experiencing the problem
- the cause, consequences, and impact of the problem

These groups and the determinant factors often set the standard and tone for policymaking. They come together with divergent views, and attempt to integrate and seek consensus on these views, in order to build a foundation, to expand on an existing foundation, and to acquire and apply new knowledge.

Policies imply a positive, projected outcome, but require the necessary, relevant ingredients, such as planning, integration, implementation, maintenance, utilization of funding, and personnel sources and resources, follow-up and research. These ingredients and others are essential for evaluation, program revision, effectiveness and adaptation.

Policies are developed by:[66]

- recognizing the problem and the need to address it
- determination of approaches and methodology, based on
  - attitudes, beliefs, culture and climate of the environment that is affected by the policy, or is part of the formulation of the policy
- creating awareness and education about the problem in it's full scope and impact

In any formation and development of policies, it is crucial to carefully scrutinize all aspects of an issue, the needs behind the issue, and the trends either propelling an issue, or those that are consequential to an issue, in order to determine if these trends are real and established patterns, and not just fluctuations resulting from specific conditions or situations.

Policymaking for Teen Pregnancy and Childbearing

In the past decade and a half, there has been an increasing volume of policies and programs to confront the range of needs and problems concerning teen pregnancy and childbearing. Policies and programs have attempted to help delay teen pregnancies, and to reduce the adverse consequences of early parenthood.

A publication from the Council of State Policy and Planning Agencies titled, Preventing Teenage Pregnancy: A Public Policy Guide,[67] states, "Since the mid-1970's, there has been an increasing body of knowledge accumulating that, in the aggregate, cumulatively can demythologize the issue and help state policy-makers formulate program options." Another recent report, Risking the Future, states, "The prevalence of adolescent pregnancy and childbearing is well documented. Knowledge about the causes and consequences of these behaviors has greatly expanded over the past decade and a half. Knowledge from the growing body of evaluation literature and accumulated intervention experience, though incomplete in many respects, suggests opportunities and directions for policies and programs aimed at solving these problems."[68]

The issue of teen pregnancy encompasses the full range of child welfare concerns that are confronting policymakers: health care, infant mortality and morbidity, poverty, child support enforcement, foster care and other care programs, child abuse and neglect, day care, education and job training, homelessness. In addition to those issues confronting policymakers regarding the issue of teen pregnancy, "Programs, planning and policy initiatives must be teen specific, that is, geared to the teen's presenting problems, and focusing on the wide range of developmental issues and life-problem resolutions, in addition to the needs encompassing teen pregnancy and early parenting, depression, drug abuse, and so on."[69]

Policies and the Diverse Needs of Teenagers

Policies must be designed that are sensitive to a diverse population of youth. "There is a lack of a coherent approach toward policy because adolescents are not a monolithic group and adolescent pregnancy is not a unitary problem."[70] Teen pregnancy as a public policy issue is often monopolized by a subjective viewpoint, since perceptions of the nature, scope, and cause of the problem vary widely according to an individual's or group's beliefs, attitudes, and value structure.

While contributing and determining factors, and the adverse, often cyclical consequences of teen pregnancy are stated throughout this report, they must be encapsulated here as implications for policy formation:"[71]

* pregnant teens who give birth are less likely to complete their education

* teen parents have diminished job prospects and are more likely than other groups to rely on public assistance

* among pregnant women under age 40, teens are more likely to seek abortions

* pregnant teens face increased health risks, especially young teens

* the children of teenagers face increased health risks

* teen parents, especially unmarried teens, face significant problems in caring for their children:
  lack of income
  inadequate health care and nutrition
  by age 5, children are more likely to be admitted to the hospital due to accidents or injuries
  stressors leading to abuse and neglect

Public policy strategies that directly address the problem of teen pregnancy and parenting recognize that there is a process involved:[72]

a teenager becomes sexually active
a teen becomes pregnant
a teen chooses to either abort or give birth
a teen keeps the baby, often becoming welfare dependent, or releases the baby for adoption

Each of these stages in the process may be considered as possible intervention points for policy strategies.

Policies and Programs

Most reports and studies acknowledge that policies should be adapted to programming in locations where teens are, and should incorporate the nature of adolescent stages of development. "Policies should incorporate adolescents' needs for information, services, and motivation for preventing teen pregnancy and building youth self-sufficiency, maturity, and decision-making, communication and independence, with an emphasis on the ability to avoid the negative consequences of teen pregnancy."[73]

Policies that are used to establish programs should consist of the provision of options based on informed decisions and choices, on practical application of knowledge, skills training, and education, and other critical elements. Policy formation must also be based on assessments of skills and abilities of the teenagers, and an expansion of options that are placed within the reach of the teens. Policy development and program implementation must also consider carefully, and incorporate how teenagers define themselves, and allow as much input and feedback from them as is possible.

A report from the National Conference of State Legislatures, State Legislative Initiatives That Address the Issue of Teenage Pregnancy and Parenting, states that public policy strategies for the issue of teen pregnancy and parenting look at the problem from two perspectives:[74]

1. The direct approach specifies that teenage pregnancy and parenting is a unique problem requiring specialized services.

2. The indirect approach asserts that the needs of pregnant and parenting teenagers can be met through services aimed at the general population.

The report states that policies take one of two tracks:

A. Strategy aimed primarily at preventing teenage pregnancy. These initiatives target adolescents before pregnancy occurs, in an effort to educate them about sexuality and the responsibilities of childbearing.

B. Strategy that targets the pregnant and parenting adolescent and is designed to assist her or him in adjusting to parenting.

"Policy development may incorporate these strategies, but rather than take a specialized approach, it may rely on related services to accomplish these goals. Under the indirect approach, the issue of teenage pregnancy and childbearing is addressed in the context of programs dealing with issues such as child support enforcement, maternal and child health, employment and job training, special education, AFDC, and child abuse prevention. Effective case management techniques ensure that pregnant and parenting teens are aware of and receive the services they need."[75] Many states do not have specialized programs that deal with pregnant and parenting teens, but address the issue and needs through related services. Some states have established specialized programs; still others have combined specialized services with related services in an integrated approach.

Most states gear their policies and program structures primarily toward teens who have already given birth and either choose to keep the baby or to release the baby for adoption, that is, the last two stages of the process. "The majority of states that have acted on the issue have sought to ensure the health of the pregnant teen and to provide her with services once she delivers. While this strategy may be effective in alleviating some of the negative health and economic consequences of the problem, it does not tackle the core issue: prevention."[76]

Policy: Federal Level

Policymaking has impacted on, and resulted from, federal programs that are aimed at the general population such as AFDC, Medicaid, Child Support, child welfare programs, and others, and have been utilized by some states, with adaptations, to address the issues of teen pregnancy and parenthood, and to address the needs of their children. In the past, before passage of the Omnibus Reconciliation Act, the federal government worked with the states in providing direction and funding for programs. Now states must provide much of their own impetus in the initiation of policy and programs, and must resort to alternative sources for funding. "Current federal involvement is limited to Title X family planning programs, Adolescent Family Life programs, consolidated block grant programs, such as the Maternal and Child Health and Social Services block grants."[77]

Policy: State Level

Polls consistently state that about 84% of Americans regard teen pregnancy as a serious national problem, yet there is no solid consensus regarding strategies to address the issue, and the problems inherent in the issue. There are many options for policy selection, practice, and implementation. "Planning, programming, servicing, and policymaking around issues concerning teen pregnancy and early parenting strikes a controversial public policy nerve: the role of the family in dealing with teenage sexuality, access to contraception and abortion, family life, or sex education in the schools, welfare and family assistance, the role of teen fathers, and fathers who are not themselves teens, in supporting their families, and a range of other areas."[78]

Nationally, and state by state, legislation, policies, practices, and programming structures are categorized as relating primarily to:[79]

* recognition of the problem of teenage pregnancy and parenting
* prevention of teenage pregnancy, that is, strategies that seek to reach teenagers before sexual activity or pregnancy
* health care during and after pregnancy, for mother and child, and mother's and child's other health needs
* social services during pregnancy or after childbirth, or before teens become at risk for these problems
* educational programs that focus on developmental needs of children and youth, with identification early in school years, or programs during pregnancy and after childbirth
* comprehensive programs
* community resource-building, and community-based services

Most states have preferred to take the second track.[80] "In most studies of programs nationally, findings are that prevention is not emphasized enough, or not at all in a broad comprehensive sense, and there is a lack of coordination among existing services, all of which cause further major problems."[81]

Many states are finding the need to increase initiatives, revise existing policies and plans, and to expand parental involvement, community involvement, and other resources in directing efforts towards preventing teen pregnancy and other related teen problems, while maintaining adequate and improved care services for pregnant and parenting teens and their children. States should examine other policies regarding welfare dependency patterns, poverty levels, incentives and disincentives, for example a state AFDC policy that requires a teenage family to live independently in order to receive public assistance.[82] This type of policy may further isolate the teenager, and remove the teen from a crucial family support system. Clearly, states need to strike a balance between prevention and intervention policies and practices, and attempt to preserve the quality of services and programs that are focused either in one or another area, or in the integration of both areas.

In the designing of state policy, states must "consider the relationship between teen pregnancy initiatives and other government or state initiatives such as education reform, dropout prevention, employment policy, older workers, etc., because of the interrelationship between teen pregnancy and many other social problems and other issues facing states that can serve as vehicles for promoting pregnancy prevention alternatives. The issue should be addressed in the context of other state initiatives, particularly in states in which the issue of teen pregnancy prevention is fraught with public emotion, and reasoned debate is difficult."[83]

Design of a prevention policy for teen pregnancy could involve one of two approaches:[84]

1. a state might decide to focus on prevention services for all teenagers, which could involve identification of all programs in which a state serves or finances services to adolescents, and building into those programs prevention components or referral mechanisms with other prevention programs; this could cause higher costs and greater effort, but would reach the desired population

2. identify teenagers at high-risk for pregnancy or parenthood and target services accordingly; this is a more realistic approach, given the financial constraints faced by states and the emotional content of the issues involved; targeting is not a sufficient approach; institutional factors that predispose certain teenagers to be at-risk for pregnancy or parenthood should also be targeted.

While most opportunities for the prevention of teen pregnancy are locally based, state government can help prevent teen pregnancy and parenthood through:[85]

* Public articulation of the issue of teen pregnancy: this could help to change public attitudes and direct attention to prevention approaches; bring pressure on systems to rethink policies on at risk students and youth; focus on media

* Statutory, regulatory, and policy changes: to utilize successful approaches under existing state programs; assistance in the coordination of multiple state programs to support local initiatives; changes are summarized as follows:

  Methods of increasing the eligibility of students served in school-based clinics.
  Methods of extending benefit coverage for services provided in school-based clinics, including:
  - Targeting Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings outreach services to adolescents.
  - Changing the state's periodicity schedule under the EPSDT program to permit more frequent screenings of adolescents.
  - Extending coverage under a state's EPSDT treatment plan.
  - Extending coverage to targeted services for children.

  Extending provider certification to school-based health clinics.
  Improving reimbursement to school-based clinics.
  Protecting the confidentiality of students.

* Financial support to local prevention efforts: can be done through a range of federal/state programs:
  Medicaid, including EPSDT
  Maternal and Child Health Block Grant Program
  Family Planning Services
  Social Services Block Grant Program
  Child Welfare Services Program
  Job Training Partnership Act (JTPA) Program
  Programs of the State Employment Service
  Elementary and Secondary Education Programs, including
    vocational education
  AFDC and other income transfer programs
  Food Stamp Program
  Substance Abuse programs
  Juvenile Justice programs

The federal government also funds Community and Migrant Health Centers in rural and urban areas, and along the migrant stream. The federal government also funds demonstration programs.[86]

* Technical assistance to local providers establishing and operating prevention programs: helping local groups to overcome obstacles to establishing and maintaining support for programs; establishing eligibility to provide services within state and federal program structures; working with program requirements; establishing working relationships with other providers; providing technical assistance to the schools, for example, in changing their environments to more constructively respond to the "marginal" student could provide an important incentive to local school districts to make needed changes; linkage of services.

* Public information services about successful strategies and connecting local providers with information, funding, and additional technical assistance: establishing a public information, clearinghouse, and brokerage service within state government; connecting local needs with potential resources.

* Documentation of the results of teenage pregnancy programs: encouraging and ensuring that the effects of various approaches are well documented for better information in the future.

The Public Policy Guide published by the Council of State Policy and Planning Agencies recommends the initiation of a State Policy Office and states specific recommendations for functions in that office.[87]

Cost Implications for States

"Preventing teenage pregnancy could be the single most important measure a state can take in avoiding both short-term and long-term costs, to the teenagers themselves and to the taxpayers."[88] As pregnant and parenting teenagers

are a major source of expenditures and lost revenue for the states, the funding of prevention programs, while expensive in the short-term, are extremely cost-effective in the long-term, both in financial, economic, and human conservation. "Each problem generated, or faced by pregnant and parenting teens involves one or more of the systems operated, financed, and regulated by state government: lost education; welfare, medical assistance; low birthweight babies and other health problems in infants and children; delayed educational abilities; teens are less likely to become significant contributors to the labor market, the labor force and the state's economy; increased divorce rates; child support enforcement."[89]

While states may be reluctant to change policies regarding eligibility for AFDC or Medicaid, and other programs, reducing or ameliorating the effects of poverty contributes greatly to the overall effort to reduce teen pregnancy and parenting, and the consequences to teenagers and their children. As the state plays a major role in the provision of income and support services to the poor, "the state can play a significant role in employment policy for low income persons and through financial contributions to a wide range of service programs, can directly contribute to local interventions to prevent teenage pregnancy. The state is in a unique position to establish policy direction and provide assistance to local groups in furthering that direction."[90]

On the basis of two years of review, analysis and discussion, the panel convened through the National Research Council found:[91]

1. Prevention of adolescent pregnancy should have the highest priority.

2. Sexually active teenagers, boys and girls, need the ability to avoid pregnancy and the motivation to do so. Delaying sexual activity is recommended. Making contraceptive methods available and accessible to those who are sexually active and encouraging them to diligently use these methods is the surest strategy for pregnancy prevention.

3. Society must avoid treating adolescent pregnancy as a problem peculiar to teenage girls. The high-risk population must include boys.

4. There is no quick fix or single approach to solving all the problems of early unintended pregnancy and childbearing. A comprehensive array of services, programs, and policies are needed to target the special characteristics of communities and to the circumstances of teenagers from different social, cultural, and economic backgrounds and of different ages.

5. If trade-offs are to be made in addressing the special needs of one group over another, priority should be given to those for whom the consequences of an early unintended pregnancy and birth are likely to be most severe.

6. Responsibility for addressing the problems of adolescent pregnancy and childbearing should be shared among individuals, families, voluntary organizations, communities and governments.

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The panel's conclusions and recommendations cover a range of activities that include research, planning, policy development, service delivery, and monitoring. The panel identified three "overarching policy goals", presented in it's order of priority, that provide a framework for specific conclusions and recommendations. The panel cautions, "inherent in this policy framework for addressing the problems... is a significant dilemma. In placing the highest priority on prevention, we do not mean to diminish the significant need for supports and services for pregnant and parenting teenagers."[92] The recommendations are as follows, with a brief summary of each:[93]

Goal 1: Reduce the Rate and Incidence of Unintended Pregnancy Among Adolescents, Especially Among School-Age Teenagers.

The panel identified three general strategies: enhance life options of disadvantaged teenagers, delay the initiation of sexual activity, encourage contraceptive use by sexually active teenagers. Central to all three is that teenagers themselves assume values that lead to responsible, healthy, and productive lives.

Enhance Life Options: Life-planning courses
Programs to improve school performance
Employment programs
Role Models

Delay Sexual Initiation:
Sex education and family life education
Assertiveness and decision-making training
Role Models
Media treatment of sexuality

Encourage Contraception: Sex education
Contraceptive services
Contraceptive advertising

Goal 2: Provide Alternatives to Adolescent Childbearing and Parenting.

Abortion: Provision of equal health care, confidentiality, dignity. and adequate counseling services.
Encourage minor adolescents, but not require, the involvement of parents and partners in the decision-making process.
Early pregnancy testing and counseling
Abortion services

Adoption: Pregnancy counseling and referral.
Adoption services

Goal 3: Promote Positive Social, Economic, Health, and Developmental Outcomes for Adolescent Parents and Their Children.

Promote Healthy Birth Outcomes and Support the Physical Health of Young Mothers and Their Babies:
Prenatal, labor, and delivery care.
Nutrition Services.
Pediatric care.

Prevent Subsequent Untimely and Unintended Births;
Contraceptive services
Abortion services

Ensure the Economic Well-being of the Teenager's Family:
Child support enforcement
Aid to Families with Dependent Children

Enhance Life Options for Adolescent Parents:
Life Management Training
Educational support and remediation
Employment programs
Child care programs
Comprehensive care programs

Promote the Social, Emotional, and Intellectual Development of the Children of Adolescent Parents:
Parenting Education: child growth and development; appropriate child care; learning techniques for stimulating infant response and development; available to male and female parents; sensitive to developmental maturity and capabilities of children and young parents

A further discussion of program options is presented throughout this report, under the various headings and sections in the report.

In the report, "School-Based Clinics: Serving Adolescents Where They Are", Joy Dryfoos states, "a motive or condition may affect behavior at several stages. Factors represent a complex process with numerous determinants operating consecutively or simultaneously, together or in opposition helpfully or harmfully, rationally or irrationally, among some individuals but not others, and some are harder to change than others."[94] Any program planning and development, policy options, and service network implementation must look at the total life circumstances, conditions, and experiences of young people, and not just view them from a single focus. Interventions must affect the behavior of adolescents in order to produce constant results and effectuate change. Many at-risk youth are forced into life situations and behaviors from a "lack of individual responsibility, maturity, knowledge and values, and due to pervasive problems associated with poverty, limited education and employment opportunities, and to live in single-parent households with the often accompanying conditions of deprivation."[95] Teens often are mature physically and immature emotionally.

Attitudes and Behavior

According to the report from the National Research Council, Risking the Future, "values, norms, and expectations that influence attitudes and behavior vary. Young people who are poor do not have the same opportunities and experiences as those from more advantaged backgrounds."[96] The report states that the levels of social, emotional and cognitive development are different, as are the abilities to establish life goals, appraise opportunities, and assess risks. The report also notes that the mobility and legal status of poor youth are different. "It is difficult to design a policy that is sensitive to our diverse population of young people."[97]

In order for change to take place, the quality of education, options and life experiences for adolescents should be improved. Program planning and service delivery systems should view the adolescent in the total life circumstances of family factors, school factors, peer influences, environmental and socioeconomic factors. The comprehensive needs of disadvantaged children and youth, and many other teenagers, must be addressed, and the costs of failing to provide for, and raise, self-sufficient youth must be calculated. In specific age groups, many have suffered "significant physical trauma or emotional deprivation and are much more likely to be functioning on a lower level due to arrested or delayed cognitive and emotional development."[98]

Teenagers and Motivation

According to Risking the Future, "all adolescents need the ability and the motivation to avoid becoming parents before they are socially, emotionally, and economically prepared. Our approach to pregnancy prevention must be targeted to the complex social, emotional, and physical needs of all adolescents."[99] All teens need to develop positive perceptions of what their lives can be.

Kristin Moore and Martha Burt in their report for the Urban Institute, Private Crisis, Public Cost: Policy Perspectives on Teenage Childbearing, "evidence documenting causality from the teens point of view - why teens make the decisions they do about sex, contraception, and pregnancy, has only recently begun to accumulate sufficiently to permit tentative generalizations. More is needed about motivation."[100]

From another report, "teens who avoid pregnancy have various support systems available to them to help them in their decision-making and in obtaining the skills and services they need to avoid conception. Those teens who delay sexual activity have the support of their families, concur with their families' values, come from smaller families with higher educational attainment and higher incomes. They do better in school and attend church more regularly."[101] The same report points out that teens who practice contraception generally follow this pattern, and also have family planning services available, are in school, and sometimes employed, and appear to have better communication skills. Important institutional factors in prevention are the family, school, social servicing agencies, and programs to reduce poverty. The mass media also plays an important role. "Fewer teen pregnancies occur when parents and children communicate effectively, parents are actively involved in supervising the dating behavior of their children, and families have adequate income."[102]

The book, How Schools Can Help Combat Student Pregnancy, contains a chapter on "Determinants of Teenage Pregnancy".[103] The authors point out that available research methodologies are inadequate in making fine distinctions about human motivation. Most questioning of teenagers about their behaviors is done after pregnancy has occurred, when feelings are altered, pressures are on them from parents, friends, and adults, and influences from the interviewers. What is believed about the teens' behaviors are often only superficial premises. "What is not known is the motivation that lies beneath forgetfulness, risk-taking, and indifference."[104] The authors state that it becomes more apparent that the root causes of teen pregnancy "are embedded in the fundamental ethos - norms, mores, institutional values - of the country. Any serious dialogue about teenage pregnancy can readily escalate into issues of ethics, racism, sexism, income distribution, and the role of young people."[105]

The authors outline some of the ways teen pregnancy is connected to social issues:[106]

1. Racism: While teen pregnancy exists in all neighborhoods, school districts, towns and cities, there is a much larger problem among low income and minority populations. The Children's Defense Fund states, "Teens have to believe that they have opportunities in order to fear losing them to an unplanned pregnancy. For many poor and minority youth the opportunities are not there. Minority children and youth have few supports available."

2. Sexism: Determination not to get pregnant is correlated with the way pregnancy affects future anticipations. The more career and educational opportunities, the more caution is taken about pregnancy. The motiva- to delay pregnancy is lessened when young women see limited career opportunities, less pay than males for the same job, higher performance expectations. Young women are often victims of their socialization process.

3. Poverty: Many researchers strongly feel that the battle for pregnancy prevention will be won around the economic front. As long as large numbers of people live in poverty with no hope of escape, no significant change will take place.

4. The Role of Young People: More research is being done on the eroding social roles of teenagers, and their diminishing place in society. Some feel that the lifestyle offered to the young lacks identity-providing roles and functions. While schooling is important, teens need economic and social roles that would provide them with an opportunity to gain competencies, approval, and self-esteem, which, in turn, would contribute to their developing identities.

5. Sexual Activity: The extent to which public opinion is aroused by teenage pregnancy as opposed to the increased levels of teen sexual activity is not clear. If teen chastity is the central issue, then debate about pregnancy and how to help teenage parents will be convoluted.

6. Policy Implications: Policy implications are intertwined with values and ideals. Formulation of policy development is difficult and complex.

The Council of State Policy and Planning Agencies report, Preventing Teenage Pregnancy: A Public Policy Guide, contains a section on the characteristics of the at-risk population. A method of understanding the factors was developed by Dr. Louise Flick of St. Louis University. Dr. Flick feels that adolescent parenthood is a result of conscious or unconscious decisions made at four separate points: to become sexually active, to not use contraceptive measures, to deliver rather than abort, and to raise a child rather than place it formally or informally for adoption. Dr. Flick grouped factors into five categories of variables:[107]

demographic: race, income, education, family size, urban/rural location
family: relationship with family members
individual: educational and occupational aspirations, sense of the future
psychological factors: knowledge, attitudes, beliefs, the nature of the individual's decision-making process
peer group
couple: relationship with the boyfriend and interpersonal communication skills

The Children's Defense Fund states, "the ability to avoid an unintended pregnancy is dependent on two factors: the capacity to delay pregnancy with an understanding of reproduction and the ways to prevent pregnancy; and the motivation to delay pregnancy with a belief that the risk of pregnancy far outweighs the inconvenience of pregnancy prevention or delaying sexual activity."

From the Urban Institute, "age at first birth is positively related to completed family size, early marriage, marital instability, and unemployment; and negatively related to educational attainment, income and job status." A report from the Institute[108] indicates important factors related to the probability of early first birth that are amenable to interventions:

1. history of school failure
2. a mother who was a teen parent
3. poor and minority families who receive welfare, or live in poverty

Stages in Decision-Making Process

The book, How Schools Can Help Combat Student Pregnancy gives several stages teens go through in the decision-making process once they are pregnant. The first part is admission that the condition exists, which is very difficult for many teenagers to acknowledge. Acknowledgement then determines the ability to seek care and services. The next is to choose a course of action. Several factors influence this process, including cultural, racial and economic background, family structure, self-concept, environment and available resources.

"White teens have a greater tendency to marry or to terminate the pregnancy by abortion. In addition, they are much more likely to place a child for adoption. Among blacks, the baby is often raised by the biological parent, her immediate family or relatives."[109]

For many teens, this is the first "adult decision" they will have to make, and is one that has many consequences, requires responsibility, and will significantly impact the rest of their lives. "Some can make the decision to abort, surrender for adoption, raise the child themselves; others are filled with suicidal feelings and a sense of deep despair and panic."[110]

The authors present a sequence of reactions that male and female teens experience in relation to their attempts to cope with the pregnancy - denial, depression, anger, resolution. The ability to progress in these decisions depends on many things - age, support networks, and level of ego strength. The reactions are outlined below:[111]

1. Denial: Young teens can delay a pregnancy test for a long time. Denial to some extent occurs with most teens of all ages in varying degrees. This is a defense mechanism designed to protect a vulnerable ego. Females may deny physical and emotional changes, males may deny paternity.

2. Depression: Adolescents may feel guilty and ashamed after getting pregnant. They may feel hurt, singled out, embarrassed, devastated by the reaction of the father of the baby, alone, overwhelmed, and without adequate resources for coping with the situation. Teens are often unable to express grief and have trouble viewing their situation realistically and asking for help.

3. Anger: These feelings are a defense against overwhelming situations. Anger may be associated with being uninformed or misinformed about her body and reproductive functioning. She may blame her mother or others, or her boyfriend for not being responsible. Anger relates to being vulnerable and unprotected, being under pressure, feeling ostracized by parents and peers, and looked down on by adults. There is a sense of feeling punished or that no one understands. She may be uncomfortable about her appearance, and may feel restricted in activities. She may feel that systems are inflexible to her needs, and that she is being taken advantage of and abandoned.
   Young men may harbor angry feelings, and may be treated as the sole perpetrator of the problem. They often do not have the support system a woman has to deal with emotions, frustrations, and fears. Men often feel alone, overwhelmed and ostracized.
   Teens often vent their frustrations on their children. The victims of the frustration are felt on all levels by parents, grandparents, school systems, community, and agencies.

4. Resolution: Teens need supportive caring people in their lives to help them sort through their feelings and options during this time. Feelings need to be expressed and worked through in order to permit these young people to move on and integrate the pregnancy experience in all its complexities. Some move along without too much trouble, others commit or attempt to commit suicide or deny the pregnancy until the last minute. Inability to formulate decisions, with appropriate supports, further contributes to a sense of failure.

The options teenagers have - abortion, adoption, parenting, single or in marriage, or placement in foster care - all bring with them complex feelings, doubts, and fears that must be strongly addressed within the order and sequence of an intervention continuum.

In How Schools Can Help Combat Student Pregnancy, the authors outline the developmental differences in pregnant adolescents:[112]

* Early Adolescents, 11-15 years: Younger teens may let the pregnancy go longer than older teens because there is a serious threat to their still unstable self-image. The younger teen often blames others for the problem. She often reacts to pressures with much increased anxiety, and young teens are more likely to make a suicidal gesture. Younger teens are greatly influenced by their own mothers. They have not yet developed the capacity for anticipating the future, and do not report changes very well. They often depersonalize the experience. Support and education are crucial.

Causal factors for younger teens are: lack of information, earlier onset of puberty and menstruation with a lack of preparedness or awareness of the ability to become pregnant, experimentation, sexual abuse, incest or rape.

* Middle adolescents, 15-16 years: This age group tends to be egocentric and self-absorbed. These teens react to pregnancy with ambivalence - they do not want the responsibility, but want something of their own. These teens see having a baby as a way of leaving home and possibly school, maturing into a woman, and becoming independent. They do ask themselves about the realities of housing, economic circumstances, and staying in, or leaving, school. The baby is often perceived as a possession. Developmental tasks are at stake, and she may become even more dependent. This age group are more realistic. Causal factors include: desire for independence, living on own, spontaneous and unplanned intercourse, belief that bad things don't happen to her, actual or threatened loss of significant person, test of boyfriend's love, escape from internal conflict, something to live for, rebellion against parents, or to separate from a too close family, loneliness, wish to raise a child the way she wished she had been raised, romanticization, lack of education, sexual abuse, testing of values, wish for acceptance, reinforcement of attractiveness or value, fluctuating stance, need for stability and support, need to make decisions on own, need for neutral space, need for peer support and empathy.

* Late adolescents, 17-19 years: This age group is the most informed, and have the most realistic perceptions of the baby, and what life will be like if they keep the baby, or make other decisions. They will accept more responsibility, and view the baby in a positive light, with a desire to mother and care for the child. These teens are more ready to care for another, and may be more ready for an interpersonal commitment. Causal factors are: attempt to consolidate identity, slip-up, conscious or unconscious, test of boyfriend's commitment, desire for maturity, desire for separation from family, sexual abuse, aversion to use of inconvenient or dangerous contraceptives.

"A clear pattern of the sense of self predicts not only the motivation of these young people for pregnancy or parenting, but also their concept of the choices available to them, their mental representations of the fetus, their choices of alternatives, and the degree of support they need. The sense of self also plays a significant role in their later reaction to the alternatives chosen, their sense of loss, and their ability to recover from the initial 'crisis' period."[113]

A report from the Urban Institute states, "most programs concentrate on the problems of teen childbearing...to the virtual exclusion of other interrelating individuals in their lives. Male partners, teen fathers, and non-teen males who father the children are ignored by most health-focused programs. Families are often focused on as providers, not as parents actively involved with others in the life of the girls."[114]

Teen Pregnancy and Poverty

In the book, Private Crisis, Public Cost: Policy Perspectives on Teenage Childbearing, the authors state, "disadvantaged youth are more hampered by a rapidly deteriorating social environment with decreased employment opportunities. Problem behaviors such as dropping out and alcohol abuse appear to cut across class lines."[115]

Due to depressed life situations, and social, economic, and educational deprivation, black and Hispanic youths account for only 27% of the nation's adolescent population, but account for 40% of the teen women who give birth.[116] Disadvantaged women, whether black, white, or Hispanic, are 3-4 times more likely to bear their children out of wedlock than are advantaged teens. An equitable distribution of income has been found to be related to lowered teen pregnancy rates.[117]

In a study conducted by the Council of State Policy and Planning Agencies, outlined by Susan Foster in Preventing Teenage Pregnancy: A Public Policy Guide, results are that teen birth rates and low incomes are related. The research consisted of a survey of all 50 states, and compared teen birthrates with the percentage of persons in poverty, the average AFDC grant per family, and the average AFDC grant per person. The results indicate that there is a positive correlation between teen birthrates and the percent of the state population in poverty, and a negative correlation among teen birthrates and the levels of AFDC grants.[118]

Success in helping low income teens delay parenthood requires renewed resources, interest, and hope - focused on the children and youth who are at-risk. Those whose families, schools, and communities do not have the means to provide the incentives and the motivation and self-belief to delay parenthood need resources and substantial, practical aid to help them along the path towards self-sufficiency. Low income teens need help in preparing for adulthood, to develop skills and interests and to explore other options and opportunities than those they feel are the only ones open to them. Low income teens need help dealing with the stresses and conflicts present in their lives.

Students must be reached and provided with supportive services long before they reach the level of alienation, disconnection, and failure that causes them to drop out of school, or society, and become pregnant or seek other options that have negative consequences to their lives.

Those who do become pregnant are those who achieve less academically than their peers, have lower educational and occupational aspirations before becoming pregnant, are more likely to be marginal students and dropouts, and those who are disproportionately from low income families.

While the large volume of research studies point consistently to the negative short- and long-term effects and consequences of living at or below poverty levels, and the devastating impact of being disadvantaged and deprived, there are young people who live in poverty, experience deprivation, and family conflicts, suffer the ill-effects of a depressed environment, yet these young people remain in school, do not become pregnant or a teen parent, work to overcome their difficulties, and who do seek positive lifestyles and do become self-sufficient, with the accompanying feelings of self-worth. There is little research on the intervening factors that determine why some youth from similar backgrounds turn to negative lifestyles, while others turn to positive lifestyles. Much research is needed on the influencing factors and determinants of behavior on the differences between these two paths, and the personal, social, familial, and the environmental, and cultural variables contributing to these pathways.

Family Factors

Positive parental involvement in the lives of children has been correlated with reduced risk-taking behavior, with better school performance, higher self-esteem, higher education and occupational aspirations, and lower incidence of teen pregnancy.[119]

Families in which adequate support, including income, is not available, suffer from a wide range of problems, either caused or exacerbated by the effects of poverty. In order to provide support for their children, families need the help to achieve economic, social, and personal levels at which they can live and function as families and members of society.

Recent studies on the kinds of family variables that influence teens' decisions on whether to initiate sexual activity, whether to use contraceptives, and how to resolve an unintended pregnancy, shed some light. The most salient features are:[120]

* living in female headed households, though the processes by which growing up in a fatherless family are not clearly understood

* lack of communication, information and education

* attitudes and actions of the family of origin can significantly affect decisions concerning management of life skills and those of the teen's child, where they will live, the continuation of school, labor force participation, child care and the relationships with the baby's father.

* teen mothers who remain in the family of origin during pregnancy and for a period after are likely to receive substantial financial and child care assistance, and this support has definite short term positive effects for the mother and child

* those who remain unmarried, who continue their education, and who themselves come from two parent households are likely to receive greater family assistance; longitudinal studies are needed to define support and coping processes and that identify long term consequences for various family members

One of the most important factors may be having an older sister as a teen parent role model. "Both this factor and the larger family size appear to be associated with greater sexual activity beyond identified effects of poverty and education."[121] The characteristics of the community and environment in which the teen resides also appears to be of major importance.

Teen parents are considered at-risk for emotional difficulties and for the potential for child abuse and neglect. Significant numbers of their children will be placed in foster care.

Teens are not sufficiently experienced, motivated, or aggressive enough to seek out needed services. Services need to be brought to where they are, and where they spend their daily lives, whenever this is possible. A report titled, "The Ecology of Help-Seeking Behavior Among Adolescent Parents"[122] states that there is a gap in understanding the teens' own definition of their needs and problems as parents, and their definitions of acceptable sources and forms of help. Some findings from the report are:[123]

1. 60% of the mothers reported they had been ready for parenting while pregnant; only 42% felt that they actually were ready after becoming parents

2. many said they felt a loss of freedom and an increased responsibility; some problems were the direct result of the termination or limitation of life choices

3. parents felt increased isolation and loneliness, and increased stress

4. the absence of a network of friends contributed to the probability of child abuse and neglect, depression, suicide, marital stress

5. pre-school children were as isolated as the parents

6. locating and finding services were a difficulty, especially affordable services like day care

7. many teens experienced role conflicts that were a source of stress

8. in seeking help for various problems, most mothers reported going to only one or two sources - 69.6%; some did not go for any help; teen parents are sometimes apathetic or slow about seeking needed assistance

The report outlines the differences in service providers' and parents' perspectives:[124]

* Parents expressed a clear need for concrete help; service providers most often provided counseling and other "soft" services with little or no concrete assistance.

* Parents expressed the need for immediate assistance when they sought help; waiting periods were perceived by service providers as shorter than by parents; length of services were perceived as too short.

* Agencies were perceived by parents as dealing only with the neediest cases.

* Many parents on AFDC wanted to become self-sufficient, but knew wages would not offset the loss of AFDC and other benefits.

* Young parents found that they were eligible for certain aid or services, but were not accepted due to limited cases taken.

* Fragmentation of services and target populations; some programs impractical, unrealistic and inaccessible.

* Young parents defined their needs and those of their children as family needs, with many needs occurring simultaneously; service providers defined needs and services in terms of separate, discrete services.

* The constellation of services parents considered essential were often provided separately or not at all.

* Young parents often felt forced into an adversary relationship with service agencies, in that the service was a hand-out or special favor.

* Young parents recognized that their needs increased dramatically after the birth of a child; many service providers concentrated on pregnancy and early postpartum period and parents felt left on their own.

The report lists recommendations to address these problems:[125]

1. Policy makers and service providers should endeavor to understand teens definitions of problems and acceptable sources and forms of help.

2. The birth of a baby is the beginning of problems for young parents. Programs should focus on parenthood and long term follow-up of parents and their children.

3. Basic life maintenance skills for women and men should be incorporated into all school curricula.

4. Infant and child care services, transportation, flexible school schedules should be made available to teen parents.

5. Family health services should be provided.

6. Contraceptive counseling and services should be made available to all young parents.

7. Programs and policies focusing on reducing the frequent isolation that teen mothers experience should be established.

8. Drop in centers, support groups, subsidized phone services, staying in school, being employed are all ways isolation feelings can be reduced. Aggressive outreach is needed.

9. Affordable, high quality and accessible infant and child care services should be made available to young parents in need of such services.

10. Policy and programs should build upon and support the family network within which young parents live.

11. Funding priorities should be given to service agencies that are changing to meet new needs, and that provide networking.

12. Service providers should coordinate their efforts to a greater extent.

13. More information about teenage fathers is needed from service providers. Efforts must be made to reach fathers, and determine their level of involvement.

14. Service providers and policy makers should be sensitive to and aware of the fact that having a child does not automatically make a person an adult.

15. Service providers should offer guidance to teen parents and potential parents with respect to decision-making.

16. Services for teen parents should include providing the basics of life, such as food, clothing, shelter.

17. Increased emphasis should be placed on providing vocational training and placement for teen mothers and fathers.

18. Supervised, post-delivery residences are needed, especially for many young single parents.

The consequences of teen parenthood in one generation recreate conditions that are antecedent to early childbearing in the next. Some factors in the lives of teens are more amenable to change than others. These points of intervention must be identified along each point of the continuum of need.[126]

The authors of How Schools Can Help Combat Student Pregnancy state that "it is useful to conceptualize two levels of prevention - primary and secondary. Primary prevention strategies attempt to keep potentially problematic situations from occurring. Primary prevention programs have such elements as family life education, health education and human development, parenting classes, developing self-esteem, vocational programs contained within their structure. Secondary prevention strategies focus on early identification of problematic situations that have already occurred, followed by interventions designed to improve the outcome. Secondary prevention includes elements such as active assertive outreach, advocacy, transportation, day care, prenatal care classes, parenting classes, counseling and family planning."[127]

The authors feel that it is of paramount importance to work on both levels at the same time. Also, "primary prevention reduces the need for secondary; secondary prevention with young parents becomes primary prevention for their children. Thus, working at both levels at the same time means a greater chance of breaking long-term destructive life cycles."[128]

The authors stress the facts that effectiveness in primary prevention results in fewer pregnancies; the effectiveness in secondary prevention results in healthier infants, fewer dropouts, and more employment and other options for teen parents. Also, "in secondary prevention, the support or lack of support that adults provide in response to the teens' situation will, in the majority of cases, determine the direction of their lives. These adult reactions will also determine the quality of life for their children."[129]

All teenagers have developmental needs and issues which must be addressed and resolved for successful maturation and growth. In working with teens on specific-behavior problems, such as teenage pregnancy, these needs must be integrated and incorporated into the various components and elements of the servicing network.

The Council of State Policy and Planning Agencies' Public Policy Guide[130] outlines categories of intervention opportunities.

- improve knowledge and attitudes about sex and contraception
- make birth control services and devices conveniently and confidentially available
- improve educational and occupational experiences
- improve family relations or develop positive relations between teens and adult figures
- improve self-confidence and self-esteem, communication and decision-making skills
- reduce risk-taking behavior
- provide adequate economic support to counter the effects of poverty

Each of these areas is further outlined and described in the book, and in other sections of this report. The following chart lists state programs by type of intervention. The subsequent charts give Programs to Prevent Teenage Pregnancy by intervention opportunities.

STATE PROGRAMS THAT MAY BE USED TO PREVENT TEENAGE PREGNANCY
By Type of Intervention

INTERVENTION OPPORTUNITIES	STATE PROGRAMS SERVING HIGH RISK ADOLESCENTS										
	Child Welf	ES	E&S Ed Voc Ed	Grant Progs	JTPA	Juv Just	Fm Pl	Medicd EPSDT	MCH	Subst Abuse	Soc Serv
Improve Knowledge and Attitudes About Sex and Contraception	X	R	X	R	R	R	X	X	X	R	X
Make Birth-Control Service and Devices Conveniently and Confidentially Available	R	R	R	R	R	R	X	X	X	R	R
Improve Educational and Occupational Experiences		X	X		X	X					X
Improve Family Relationships or Develop Positive Relationships Between Teens and Adult Figures	X		X	R		X		X	X	X	X
Improve Self-confidence, Self-esteem, communications, and decision-making skills	X	X	X		X	X	X	X	X	X	X
Reduce Risk-taking Behavior	X		X		X	X	X	X	X	X	X
Provide Adequate Financial and In-Kind Support to Counter the Effects of Poverty	X	X		X	X		X	X	X	X	X

X - Programs now covering or potentially able to cover pregnancy prevention programs.
R - Programs which could be used to provide systematic referrals to other prevention services.

Source: Preventing Teenage Pregnancy: A Public Policy Guide, Susan E. Foster, The Council of State Policy and Planning Agencies, 1986.

INTERVENTION OPPORTUNITIES	EXISTING PROGRAMS	EFFECT ON TEEN-AGE PREGNANCY	COMMENTS
IMPROVE KNOWLEDGE ABOUT SEX AND CONTRACEPTION	• Sexuality education programs • Family life education programs EXAMPLE: Short courses, comprehensive courses, peer education, parent-child education, conferences, and counseling provided in clinics	• Effective in increasing participants knowledge about sexuality and birth control • Do not increase permissiveness in sexual attitudes or increase sexual activity • Parent/child programs increase comfort and frequency of communication about sex • No clear demonstrated impact on pregnancies unless combined with clinic programs below	• Sexuality education courses, regardless of type, are overwhelmingly favored by both teenagers and parents of teenagers who have participated in such courses. Their greatest effect in terms of knowledge gains and increases in parent-child communication seems to be with younger children.
MAKE BIRTH-CONTROL SERVICES AND DEVICES CONVIENTLY AND CONFIDENTIALLY AVAILABLE	• Sexuality education/clinic programs in schools • Family-oriented clinics associated with other institutions • Free-standing clinics • Physicians office services EXAMPLE: Maternal and infant Care Program of the St. Paul Ramsey Hospital, St. Paul, Minnesota - school-based clinic	• Research to date suggests that the provision of contraceptive services and supplies in a confidential manner, easily accesible location, characterized by frequent follow-up and provided by adults who care about the teens they serve can by particularly effective in reducing the rates of teenage pregnancy.	• The school-based clinic approach, proved successful in St. Paul, has been extended to other schools in the city and is continuing to demonstrate its effectiveness. Similar programs now operating in 18 cities while another 25 communities are planning to develop such programs.

INTERVENTION OPPORTUNITIES	EXISTING PROGRAMS	EFFECT ON TEEN-AGE PREGNANCY	COMMENTS
IMPROVE EDUCATIONAL AND OCCUPATIONAL EXPERIENCES	• Remedial education of basic academic skills • School retention to provide diploma • Vocational training for immediate employability • In-school work experiences • Pre-employment assistance • Public sector work experience • Remedial education and training • Institutional changes in school system, such as alternative schools EXAMPLE: NYC College High School, Queens, NY alternative school; JDTPA and WIN programs and demonstrations; in school voc-ed and cooperative programs	• These programs have not been evaluated in terms of their reduction of rates of pregnancy • Caution should be exercised in using full time employment as a prevention strategy for teen pregnancy; rather, consider creating a safe and constructive environment where teenagers can mature fully before entering the world of work on a full time basis. This will require significant changes in our schools. • The NYC College High School program has demonstrated an 85% enrollment rate in college or vocational school.	• While a direct link between school retention rates and pregnancy prevention has been proven, anecdotal evidence suggests a positive correlation

TYPES OF INTERVENTION STRATEGIES

INTERVENTION OPPORTUNITIES	EXISTING PROGRAMS	EFFECT ON TEEN-AGE PREGNANCY	COMMENTS
IMPROVE FAMILY RELATIONSHIPS OR DEVELOP RELATIONSHIPS BETWEEN TEENAGERS AND ADULT FIGURES	• Parent/child sexuality education programs • Family counseling services • Family life programs of some religious institutions	• Joint parent/child sexuality education programs have been shown to increase parent-child communication about sex and to a lesser extent about birth control with younger students. With older students, the effects are not as pronounced although still significant for communication between teen and staff of service organization may be important. • Approaches of religious institutions and of involving the mothers in decision making and problem solving should be explored	• While such programs improve communciation, no effects on sexual activity, pregnancy or effective use of contraception have yet been demonstrated. • These programs appear promising, however, as reserarch has shown that teenagers who are more closely involved in a positive relationship with parents become sexually active later and use contraceptives more.
IMPROVE SELF-CONFIDENCE, SELF-ESTEEM, COMMUNCATIONS, AND DECISION-MAKING SKILLS	• Some comprehensive sex education courses include activities desired to promote ego development • Programs designed to keep teenagers in school or working may contribute to this goal. • Cognitive-behavioral approach to provide teens with the skills to better influence their environment.	• Sex education courses have demonstrated no impact on self-esteem • The cognitive-behavioral approach appears to be increasing sexual knowledge, problem solving abilities, and patterns of succcessful communication, and to more favorably dispose participants to family planning and effective use of contraceptives	• The school-based clinic approach, proved successful in St. Paul, has been extended to other schools in the city and is continuing to demonstrate its effectiveness. Similar programs now operating in 18 cities while another 25 communities are planning to develop such programs.

INTERVENTION OPPORTUNITIES	EXISTING PROGRAMS	EFFECT ON TEEN-AGE PREGNANCY	COMMENTS
REDUCE RISK-TAKING BEHAVIOR	• Substance abuse prevention (including information management of internal urges to use drugs, and social resistance skills) intervention and treatment programs • Delinquency prevention and treatment programs	• These programs have not been evaluated in terms of their effect on teenage pregnancy. • Informational and affect management approaches to drug abuse prevention show no effect or greater drug experimentation • The application of the social resistance approach deserves further consideration. • Provide support, nurturance from families, communities, schools, etc. that children need in order to avoid risk-taking behavior	• Sexuality education courses, regardless of type, are overwhelmingly favored by both teenagers and parents of teenagers who have participated in such courses. Their greatest effect in terms of knowledge gains and increases in parent-child communication seems to be with younger children.
PROVIDE ADEQUATE INCOME SUPPORT TO COUNTER THE EFFECTS OF POVERTY	• Pre-employment assistance • Public sector work exerience • Private sector access experiences • Remedial education and training • Federal/state income and in-kind assistance programs	• Low income persons are at much greater risk for teenage pregnancy than those coming from families with incomes above the poverty level.. • The incidence of children in poverty has been increasing in recent years.	• Establishing a sound and workable employment policy and expanding and using income transfer and in-kind service programs to provide a firm underpinning of financial support to poor families should be considered important if not essential elements of any concerted effort to prevent teenage pregnancy.

The report, Private Crisis, Public Cost, states that there are multiple intervention points in a servicing model:[131] sexual activity level; contraceptive use; pregnancy resolution; educational attainment; welfare dependency.

The report notes that intervention is easier and less costly earlier in the process. An example is intervention before pregnancy and within the family or local community, rather than after pregnancy and at the national level.

The report states that service providers, researchers, policy makers and families must work together to meet the needs of teens. Further research is needed on which kinds of services are the most effective, the impact of services, and which kinds of services are cost-effective. "Affecting government and other institutions will have an impact only to the extent that these organizations affect individual behavior."[132]

In a survey of 40 programs, "Working with Teen Parents", key ingredients were identified by the Family Research Coalition in Chicago:

1. assertive outreach programs
2. comprehensive services
3. strong support from staff and from parents and partners of teens
4. solid educational skills relating to both parenthood and employment
5. assistance in planning for the future
6. long-term follow-up efforts

Joy Dryfoos in her article on prevention strategies,[133] states that prevention strategies are usually based on three program models:

* programs to impart knowledge or attempt to develop or change attitudes regarding sexual behavior
* programs that provide access to contraception
* programs that enhance life options - in schools, employment, youth servicing agencies

Dryfoos believes that life options programs "may supply the missing components of effective pregnancy prevention by reaching out to implement crucial changes in the social environment."[134]

Due to the diverse needs of teenagers, comprehensive and case-managed services are critical componenents that are the most viable and workable.

Communities can contribute through resource-building, utilization of existing resources, networking at all levels that is integrated and coordinated. Communities can conduct assessments of need, identify gaps, identify leaders - teens, adults, church leaders, schools, businesses, industry, teachers, teaching hospitals and universities.[135]

An equitable delivery of services is critical in reaching and servicing teens who cannot, or are unable to, access to services. A comprehensive continuum of services is crucial to effective programming for prevention and intervention, as single problem solutions to multiple problems are ineffective and inconclusive. Coordination helps to develop and expand resources. Networking helps to facilitate services, reduce duplication, coordinate approaches, and streamline the delivery of services for early and easy accessibility.[136]

Overview

The Children's Defense Fund, in the report, "Programs That Help Prevent Adolescent Pregnancy and Build Youth Self-Sufficiency", reports, "Data showing persistent gaps between the pregnancy and birthrates found among middle-income teens and poor teens makes it equally clear that America has a task at hand that stretches well beyond sexuality education and contraceptive services. Success in helping low income teens delay parenthood will require that renewed resources, interest, and hope be focused on children and youth who are at-risk - children whose families, school, and communities do not have the means to provide incentives to delay parenthood and to help them along the path toward self-sufficiency."[137]

Low income teens need help to prepare for adulthood through assessments of their basic skills and interests and enhancement of these skills and interests, opportunities for evaluations, with services and support systems to meet the results of the evaluations. Help is needed for these teens who must deal with stresses and conflicts in their daily lives, and who experience negative behaviors as a result of these stresses and conflicts. These teens need "concrete and detailed explanations of how they can achieve", and to be provided with compelling reasons to believe that they can achieve their goals. There must be "comprehensive efforts to help teens become motivated to prevent early sexual activity and pregnancy, and they must have the increased capacity to do so through improved information, guidance and services." The Children's Defense Fund points out that programs and services designed to help families meet their children's basic needs as they prepare for adulthood, combined with sexuality-related information and health services, help to reduce teen pregnancy.[138]

CDF outlines three categories of programs:[139]

1. Developing Skills/Setting Priorities/Building Self-Esteem: These programs deal with adolescent sexuality and pregnancy prevention in the context of meeting teens basic needs for skills development, confidentiality, exposure, ideas and opportunities to achieve adult self-sufficiency.

2. Getting Health/Staying Healthy/Avoiding Pregnancy: Program types include comprehensive adolescent health clinics; school-based and school-linked health services; hospital-based services; free-standing medical outreach care units, and other programs that provide a range of primary health services.

3. Multi-Service Centers: These programs combine reproductive and general primary health care services with basic programs in education, recreation, and/or employment training.

CDF states that efforts should be made to combine broad, self-sufficiency-building programs with more targeted pregnancy prevention. The argument can be made that "any program offering reproductive health counseling and services to sexually active teens works to reduce teen pregnancy rates, and provides for the unmet general health needs of adolescents, particularly low-income adolescents."[140] CDF suggests that reproductive health care for teens should be provided within the context of comprehensive primary health services.

Any program, service, or policy that encourages teens to remain in school, build academic and work skills, provides work experience, promotes incentives for self-sufficiency and self-esteem, and expands realistic horizons, with the accompanying means and support systems to achieve these expansions, is teen pregnancy prevention.

Research states that often early childbearing can be the product of low socioeconomic status and the lack of opportunities and experiences among minority young men and women, and other groups of poor children and youth. "Therefore amelioration of some aspects of the social environment should precede or accompany reproductive health interventions such as sexuality education and family life education."[141]

Teen perceptions that their lives would be no worse off, and perhaps even better, than becoming pregnant, need to be altered, and supported by adequate services, counseling and practical realities and options that are relevant and achievable in their lives. Joy Dryfoos states, "mechanisms must be designed and implemented to motivate teen mothers and fathers to strive for enhanced employment options and to make sure that opportunities to have these options materialize are in place."[142] Many researchers point to the fact that the structure of programs designed to aid the poor directly and indirectly maintains some groups below the poverty level, provides disincentives to independent status, and ignores large categories of the needy.[143]

Dryfoos and others state that it is critically important to protect and maintain existing programs, in addition to the prosidion of new initiatives, so that continuation of care and accessibility are assured for those who rely on services.

The Alan Guttmacher Institute , in 1981, in "Teenage Pregnancy: The Problem That Hasn't Gone Away", "Teenagers, especially those who are very poor, need to believe that completing their education can really lead to meaningful options in the world of work, that there is potentially more out there for them than dead-end, low-paying jobs."[144]

Dryfoos states, "the concept of broader interventions might be needed in order to prevent pregnancy has been around for quite a while. It has not been operationalized to any significant level."[145]

National Program Strategies

Program strategies nationally have been organized around interventions in the schools, formation of coalitions, task forces, involvement of family members, churches, social organizations, through the media, and by resource-building and development, networks, and collaboratives within the community. Research studies consistently state that no one isolated program or service delivery system alone is effective in the prevention of teen pregnancy and early childbearing. Many parts of the country have extensive, comprehensive, multiservice and interdisciplinary programs and service networks in place that are community and inter-community-based. These collaboratives and networks involve state, federal, and local agencies, public and private agencies, institutions and facilities, advocates, service providers, and funding sources. Free-standing services have been found to be somewhat ineffective of themselves, in that teenagers, as a group, do not access themselves to services. Also, knowledge-based information alone, has been found to be not fully effective in delaying sexual activity, pregnancy, and childbirth in teens. An example of this is sexuality education which, while

proven to be effective education for teens, and in imparting knowledge, is not fully effective in detering teens from early sexual activity, irresponsible sexual behavior, pregnancy and childbirth. Comprehensive programs that are in place and functioning to service a range of adolescent needs are better able to act and react to changing adolescent needs, rather than reacting to problems that have reached a crisis level.

Many programs that have developed nationally have been in place for over a decade, and have expanded according to need, rather than be in a constant state of reacting to crucial problems after they have occurred. Most of these began at the community level, then were expanded to the regional and state levels, with a state commitment. Many programs developed nationally contain certain elements and components, and are then adapted to local populations, community needs and resources. One of the first steps many programs have taken is to bring services and programs to where the youth are - in schools, communities, teen centers and clinics, and to involve youth in services and programs that are relevant, feasible, and appropriate to their needs, and the needs of the particular environment in which they live. Real and perceived barriers must be removed or reduced to manageable levels. Coordination and case management are essential components, and sound information systems, streamlined referral systems, and a single point of entry into servicing systems wherever possible, are critical elements to effective interventions. Ensuring appropriate linkages of services is a valuable technical assistance that must be provided to meet the complex needs of teenagers.

While there are many variations in methodology, approaches, policy development and application, service systems designs, and follow-up services, usually due to diversification in the needs of teenagers, location, community identity and resources, there are consistent elements and components that have proven to be effective in programming and servicing the full range of teens' needs, including pregnant and parenting teens, and in the early identification of high-risk and potentially high-risk youth.

The servicing model included in the report is a composite of elements and components that consistently emerged from a review of national programs that have proven to be effective at some level of intervention. The main features are outlined under the various headings and categories that they most often appear, and in the locations with which they are most frequently identified. Key elements to effectiveness for any one service, or service delivery network, have been identified as outreach and tracking, coordination, collaboration, networking, and case management. Many communities have well-utilized local hospitals, universities, and businessmen and businesswomen, as well as tapping into innovative resources, and mobilizing community support and volunteers. Needs and problems to be addressed are viewed in the context of a range of services to meet the particular presenting problem, developmental issues, and associated corresponding needs and behaviors. Many programs employ student, parent, professional, and community advisory boards and councils.

Many programs have expanded services to increase in-home assistance, such as parent aide programs, role-model programs, peer support groups and parent-teen support groups.

States are looking at increasing family responsibility and capacity. Several states are mandating the extension of health insurance coverage to include a dependent minor's child.

Pregnancy Prevention and Preventive Interventions

Pregnancy prevention services ideally should combine:[146]

* an effective educational component
* full range of family planning services
* counseling to aid the teen in grappling with life decisions and problems
* counseling to help with making informed decisions and choices about lifestyle and life options and decisions
* support to aid teens in placing these options within reach
* practical decision-making; communication; basic skills development
* skills training and education

"Programs and the policies behind them must offer components, while simultaneously strengthening skills, broadening experiences, increasing opportunities - through education, employment training, exposure and experience, recreation, health care, and family support systems."[147]

The panel convened by the National Research Council presented it's findings in Risking the Future. Conclusions and recommendations of the two year study are presented in their report "with an intense awareness of the limits of scientific knowledge in dealing with problems of adolescent pregnancy and childbirth. The issues involved also reflect widely differing values."[148] The panel recognizes the importance of the family in establishing values and behaviors, and encourages efforts to involve families as an essential component in the solution of the problem.

The panel also states, "Public policy and programs should be directed at minimizing the risks associated with early sexual activity and at helping teens become responsible for their actions. The costs of prevention are far less than the costs of amelioration of the likely negative social, economic, and health consequences of early childbearing."[149]

Most programs involve direct approaches to the problem - that is, interventions intended specifically to influence decision-making processes at the time of choice, such as family planning services. Other programs involve indirect approaches - that is, interventions intended to alter the conditions of decision-making, such as "the ecological context of the individual and his or her personal characteristics."[150] Examples are remedial education, occupational and family formation goals.

The panel of the National Research Council, in it's evaluation of programs and services, states that programs are based on assumptions that broadening opportunities, especially through educational enhancement, provide meaningful alternatives to childbearing. The panel points out that many programs have not been rigorously evaluated, and gives the reasons for a lack of systematic information on the effects and effectiveness of programs:[151]

1. Many programs have failed to clearly define their objectives as a basis for measuring outcomes. Programs have often failed to distinguish between direct and indirect outcomes.

2. Unlike the reduction in the numbers of births to teens, a reduction in the numbers of pregnancies is difficult to measure.

3. The reduction in the number of pregnancies may reflect a variety of factors other than, or in addition to, program effects. Examples are changes in the age and racial characteristics of the target population, changes in local school policies and populations, and other factors that confound evaluations.

4. In addition to methodological impediments to accurate evaluations and other practical problems, it is expensive to do research. Service providers may lack research and technical skills. Funds may last for short periods of time, but not long enough for sustained research efforts.

The panel notes that during the past 15 years, there has been a great increase in the number and variety of interventions aimed at preventing teen pregnancy and childbirth. "Virtually all represent strong underlying assumptions concerning the nature of the problem and what constitutes the most appropriate and effective approaches to solving it."[152]

Many states, including New York and Connecticut, are emphasizing youth and family development programs as priorities in effective preventive strategies. According to the New York "Second Report of the Governor's Task Force on Adolescent Pregnancy", January, 1986, "Moving Forward: Next Steps", "effective prevention strategies must be anchored in systematic networks of supports and services that promote positive youth and family development. This encompasses a broad array of activities-family support networks, ensuring the provision of adequate nutrition and health care, improved availability of day care, education and vocational services, employment opportunities and parenting education." The basic premise underlying the promotion of and enhancement of, youth and family development, is the need to strengthen the capacity of communities and basic institutions such as the educational system, local governments, the medical community, formal and informal community networks, and churches and other religious institutions, to respond to the needs of all children and families.

The report of the Governor's Task Force further states, "prevention strategies that emphasize youth and family development take a fundamental approach to addressing the causes of adolescent pregnancy. Such programs will enhance the capacity of communities to promote and support healthy youth and families." Communities' groups and institutions reflect the culture and tradition of communities, and represent frequently untapped resources.and community strength. Programs emphasizing youth and family development must be balanced with the need for continuing services for preg-

nant and parenting teens, and all high-risk adolescents.

Recommendations from the New York Governor's Task Force emphasizing youth and family development include:[153]

1. delineating relationships among the various problems experienced by adolescents and their families; determining the common root causes of the problems

2. development of coordinated, integrated efforts to address a variety of problems through a youth and family development framework

3. focus on building the capacity of basic institutions to equip young people and families with the necessary skills to participate in society

4. identification of existing resources; needs assessments

Joy Dryfoos, in her report on Prevention Strategies[154] discusses the costs of various aspects of programs and programming components. The costs of day care programs and school-based programs are discussed under the sections pertaining to these areas. The following are areas of Dryfoos' cost analysis:

1. Programs that impart knowledge or change attitudes:
   a. Most sex education courses in schools or in community agencies cost very little. A few school systems employ full time sex educators.
   b. More innovative programs are often initiated and funded outside the school system, and services are brought into schools by service providers.
   c. Estimated costs of such services are about $40 per pupil per year.
   d. The use of media for imparting knowledge about reproduction and responsible sexual behavior has generated interest.

2. Programs that provide access to contraception.
   a. Studies of family planning clinics have shown that the cost per patient per year is under $100. Serving teens costs slightly more.
   b. Patients pay only a fraction of the cost; the amount depends on their income, age, and on clinic policies regarding co-payment.
   c. Private physicians charge higher fees. An estimate of a year of private physician care for family planning is $131 to $172, including pills.
   d. Costs of school-based comprehensive care programs that include sex education and family planning range upwards to $320. Others state costs at from $100 to $200 per patient for a year of services.
   The costs for multi-service programs per patient per year is the same for free-standing clinics.

3. Programs that enhance life options.
   a. For programs that deal with problems of teens, the more intensive the care, the higher the cost. The Bridge serves about 2,500 clients with a budget of $600,000, averaging $240 per client. Many volunteers work in this program and the configuration of services per client varies widely.
   b. Alternative school programs do not generally have additional costs over and above the costs of regular secondary education, about $2,000 to $3,000 per pupil per year. Since schools are reimbursed by states according to ada, average daily attendance, school systems gain by having truants and dropouts in schools.

c. An intensive and effective program for training and placing teen mothers in jobs in New Orleans, reported annual costs of $1200 per client. A summer program in Atlanta costs about $1000 per teen.
d. It is estimated that a state level organization with sufficient staff for public education and advocacy might cost in the range of $100,000 to $200,000.

Cost Per Birth Prevented

Interventions that may impact directly or indirectly on the prevention of pregnancy have a cost range from nothing to hundreds of dollars per client year of service. Dryfoos estimates costs averted through prevention at $1,000 to $1,363 per birth. This does not include the costs of more specialized services that might be needed. Dryfoos suggests that foundations could develop more communication in order to allocate resources comprehensively, initiate research standards, avoid duplication and share the results of successful programs. 155

Media Campaign

The Children's Defense Fund, the Center for Population Options, and other groups and organizations have implemented media campaigns to combat and create awareness and conscious-raising about teen pregnancy and it's consequences.

The Children's Defense Fund has organized a media campaign, consisting of radio spots, advertisements in schools and bus stops, to avert teen pregnancy. "Teens need the means, through family life education that encourage abstinence or birth control for those who are sexually active, and the motivation to avoid early pregnancy and childbearing." The campaign tells teens of the consequences of teen pregnancy, and that future options do exist.

The campaign is a multi-media, 5 year campaign designed to create national climates of concern about the teen pregnancy crisis. The first stage is aimed at adults to remind them that teen pregnancy can affect their children. Through public service announcements, the message is that teen pregnancy is a national problem. Ads are directed at junior and senior high school students.

Effectiveness Studies and Evaluations of Programs

The U.S. General Accounting Office issues a "Briefing Report to the Honorable John H. Chafee: Teenage Pregnancy, 500,000 Births a Year But Few Tested Programs", in July, 1986. The report analyzed two bills currently proposed that are concerned with programs addressing teen pregnancy. The report also studied national programs addressing pregnant and parenting teenagers, and stated the results of the evaluation. The bills proposed were those of Senator Chafee, S938 and Senator Moynihan, S1194, which would amend AFDC programs. Senator Chafee's bill, discussed in Section 3, is targeted to a specific group - poor teenagers younger than 18 years, provides flexibility with regard to comprehensive programs, and the administrative structure is straightforward. Senator Moynihan's bill, also discuss-

ed in Section 3, is targeted more broadly, and includes teens eligible for AFDC and selected young women with children younger than 6 years, is specific in the services to be provided, involves prevention and postpregnancy services, and is administratively complex. This bill involves coordination across five federal programs.[156]

The report states that programs are generally of two types, or approaches: efforts to prevent teen pregnancy; services to teens who are pregnant and parenting that aim to prevent or lessen the negative consequences. "Within these two general approaches, there have been identified distinct strategies that differ in the location within which services are provided, the types of services that are provided, and who they are provided to."[157]

The GAO conducted a national survey of 153 of the largest cities in the country, asking local health and education departments about specific programs for pregnant teens. Of the 127 that responded, 90 stated that special programs for pregnant teens were provided, and that most received public funds from one or more sources: 67% received local funds, 59% received state funds, and 47% received federal funds.[158]

In various states, local funds came predominantly from education systems; federal funds came from block grants for maternal and child health and for social services. About 70% of the cities reported that education funds were a source of support for special programs for pregnant teens; 33% reported health funds, 12% reported welfare or social service funds.[159]

Six programs provide services relevant to poor pregnant and parenting teens: maternal and child health block grants and the social services block grants; programs for community health centers; employment services and job training grants (demonstrations under JTPA); child welfare grants; and community services block grants.[160] National information on funds is not maintained. In the above programs, the federal role is secondary to the local role.

The report points out that there are flaws in study designs in some of the effectiveness evaluations conducted on programs. These related to the possibility that factors other than program participation influences the results in some programs. The report reviewed Adolescent Family Life Programs and other programs. Findings from the survey are:[161]

* While information is limited, there are positive results of the programs, and no demonstrated failures.

* While there is no evidence that sex education reduces teen pregnancy, there is no evidence that it increases sexual activity.

* There is insufficient evidence for any conclusion that some services are more effective than others.

* Teen mothers who were enrolled in service programs provided a range of assistance that included prevention services, had lower fertility rates than teens in similar communities without such programs. Increased use of birth control was reported in the first year after the birth of a child.

* Positive results were reported in other areas, such as the health status of children, and the mother's school attendance and school achievement.

* Prevention programs only revealed some positive results, but no consistent or large effects on fertility or contraception use was found. There were some positive short-term effects on repeat pregnancies, child health status, and the return to school of the teen mothers.

* There is a need for administratively simple program structures, and to focus on young and unmarried teens in the targeting of services.

* Three grant programs were also studied: Family Planning, Employment Training Services for the Disadvantated under JTPA; and the Special Supplemental Food Program for Women, Infants, and Children, WIC. Information on funding for these programs is not maintained.

* Teens receiving a broad array of services had no fewer complications and no healthier infants at delivery than teens receiving at least prenatal health care. However their children were more likely to receive regular health checkups.

* Teen mothers enrolled in multiservice programs were more likely to return to school and to complete more years of school after delivery than non-participants.

* Generalizations were difficult as gains measured are usually limited to one year.

* Hospital-based comprehensive programs usually cost about $775 per mother and child, beyond the cost of pregnancy, for making social service referrals, and providing weekly family planning and group counseling sessions during pregnancy and a 2 year follow-up.

* For many programs, cost assessments are difficult to establish, as there are often many factors involved. Analysis of time-series data is needed.

* There is an unmet need for services for pregnant teens, but much uncertainty about which services are most effective.

* There are four distinct avenues that could be pursued in future legislation:
  1. expanding services where they are most needed
  2. support well-evaluated demonstrations of innovative, flexible, and clearly targeted programs
  3. promising approaches have been in the areas of providing vocational training to young fathers, providing academic assistance and counseling to teens at-risk of dropping out, and developing a pregnancy prevention curriculum from models on the influence of beliefs and attitudes on behaviors conducive to good health
  4. Federal efforts should be focused on a three-pronged approach that encourages innovative models, evaluates them, and disseminates those that have been tested and appear to be promising.

Studies on Federally-Funded Programs

In a report in 1985 for the American Public Welfare Association, by Martha Burt and Freya Sonenstein, "Planning Programs for Pregnant Teenagers",[162] 21 federally funded care programs were studied for cost-effectiveness, and for program component evaluations. One of their findings was that very few contained primary preventive components - most programs focused on care services for teens already pregnant, or who had at least one baby.

Many types of agencies served as primary delivery sites - schools, health agencies, hospitals, and special adolescent pregnancy programs. The average caseload was 300 female clients, and numbers ranged from 50-700 clients. The analysis of the programs was based on 1,054 clients who had entered a program either pregnant or with a baby, and who had at least one follow-up after the baby's birth. Information was taken from client's records:[163]

1. teen's entry characteristics
2. data on service delivery
3. information on pregnancy outcomes
4. education and vocational achievement
5. employment and welfare status
6. follow-up on repeat pregnancies

The authors determined what constituted a typical unit, what professional delivered the service, and how often a client typically received the services. A flat fee was computed, along with a unit cost based on staff time, overhead, and related expenses. Comparable data was gathered from off-site services, therefore the authors were able to "determine unit costs for each service, including direct costs, overhead costs, counseling services, the preparation time of professional staff prior to direct contact with the client."[164]

The ten core services studied were:

pregnancy testing and maternity counseling
family planning counseling and services
primary and preventive health care
nutrition counseling and services
venereal disease counseling and services
pediatric care
family life/parenting education
educational and vocational counseling and services
adoption counseling and services
other health care

Supplemental services are: child care, consumer/homemaker education, counseling for partners and extended family, and transportation.

Results of the evaluations were:[165]

* The characteristics of individual programs make a significant difference in the types and amounts of services that clients receive
* The shorter the length of the follow-up, the more services of all types clients received.
* Rural projects delivered fewer services of most types and fewer services overall, but rural programs should not receive lower funding priorities.

* Although some hospital-based programs have been able to develop effective comprehensive services, experience and study shows that hospital-based programs do not do as well as other programs. Hospital coordination is difficult.

* The higher the percentage of on-site services, the lower the diversity. Clients did not get as many different kinds of services.

* Programs that use referrals to other common agencies for a high percentage of their services have as good or better a track record than those providing services.

* Services provided under one roof succeed in delivering a range of services.

* Teen women who were pregnant when they entered programs received more services than those who already had one or more children.

* Teen women on welfare received more services than those who were not.

* Client age, race, school status, and number of previous pregnancies or children did not affect the number or type of services received.

* Agencies must develop interagency coordination and allow adequate time for this to be carried out; agencies must establish clear guidelines for case management, tracking clients, and keeping adequate client records.

The authors state the basic premises of case management as being: [166]

1. a way of identifying all clients served by the program

2. a system for assigning each client to a case manager who will be responsible for assuring that the client receives the needed services

3. a means of determining which services the client needs, with periodic reassessment

4. a method of confirming receipt of services given both by the program and by referral agencies

Failure to receive services within a reasonable time should trigger an inquiry into causes of the problem.

Arizona

The Arizona Council on School-Age Parenting (ACSAP) is a statewide organization that promotes public awareness of the special problems of school-age parents, and helps develop, coordinate, and expand services for this special group.

The work of the Council includes:
conducting conferences and workshops each year
sponsoring special programs and studies
arranging for technical assistance to voluntary and public agencies
promoting legislation and maintaining liaison with government units at state, county, and local levels

Each year, the Council develops a work plan that identifies key activities for the year. In 1980, two statewide activities were a conference for professionals, adolescents and parents, and an experimental radio campaign. The theme of the conference was "The Teenage Father". The next conference focused on the babies of teen parents. Information on ACSAP can be obtained by contacting Dr. Shirley O'Brien, School of Home Economics, University of Arizona, Tuscon, 85721.

California

The California Alliance Concerned with School-Age Parents (CACSAP) is a statewide effort aimed at the concerns and issues around pregnant and parenting teenagers. It's members come primarily from the health, education, and social service professions, but young parents, students, and families are also encouraged to join the group.

CACSAP is a non-profit membership organization that:
provides and exchanges information on new developments, pending legislation, and other areas of interest
acts as a lobbying group on behalf of school-age parents
works with state and local decision-makers to improve educational, social, and medical services

CACSAP has a Legislative Task Force that monitors legislation in the state, especially changes in the laws relating to teenage pregnancy and parenthood. Conferences conducted by the Alliance include workshops on such topics as adoption, counseling, teen fathers, nutrition, sexual abuse, mental health, legislation, burn-out, parenting, domestic violence, and grant-writing.

CACSAP works with teen alliances in other states and is planning to co-sponsor a Western States Conference for professionals who work with pregnant teenagers and teenage parents. Further information may be obtained by contacting Merle Church, P.O. Box 3132, Manhattan Beach, Ca. 90266.

Connecticut

The General Assembly created the Task Force on Education to Prevent Adolescent Pregnancy in 1984, in order to examine the extent and nature of the problem in Connecticut, to identify available services and gaps in services for pregnant adolescents, to determine public and private costs, and to recommend a coordinated approach to the use of current resources to reduce the number of adolescent pregnancies.

The Guiding Policy of the Task Force, as stated in the report, State of Connecticut Report on the Task Force on Education to Prevent Adolescent Pregnancy, is: "Educating young people is the primary importance of family life and the serious consequences of premature sexual experience and childbearing is in their own best interests and that of the State of Connecticut."

The Task Force consisted of several subcommittees: Coordination, Education, Medical/Health, Social-Employment, as well as formulating recommendations in the areas of policy, legislation, and issues requiring further study. In addition, public programs were studied and recommendations made for each agency, along with a statement of the problem.

Recommendations of the Coordination Subcommittee:

* Establish a Teenage Pregnancy Prevention Council within the Office of Policy and Management comprised of various commissioners. The Council would:

  develop a statewide policy and strategic plan for adolescent pregnancy prevention and insure that this plan is implemented
  identify problems and deficiencies in services available throughout the state
  recommend ways to improve coordination of resources among state and local agencies, public and private
  coordinate research among member agencies to assure uniformity of data
  report annually to the Governor and General Assembly on its activities and recommendations

* Create a state Adolescent Pregnancy Prevention Grant to provide an incentive for communities to coordinate their services. Monies would be set aside for planning grants to encourage communities to enter into the Negotiated Investment Strategy process.

Recommendations of the Education Subcommittee:

* Mandate family life education in grades K-12, phased in over 4 years.
* Community Advisory Councils for curriculum development and mandated in-service teacher training.
* Support for the SDE budget request in matching grants to localities for high school-based day care.
* Further study:
  conduct an in-depth study of school districts to determine existing status of family life education programs
  develop a means of evaluation of existing family life education programs to determine effectiveness
  determine effective ways of using news, entertainment, and other media to promote the messages of family life education

Recommendations of the Medical/Health Subcommittee:

* Establish school-based health clinics.
* Adoption of a "Mature Minor" statute.
* Improved reporting of health statistics to the Dept. of Health Services.
* Study changes in the reimbursement of community health clinics.

Recommendations of Social-Employment Subcommittee:

* Implement model program of subsidized job training and placements in the Department of Income Maintenance through AFDC and JTPA grant diversions.
* Direct state support toward programs patterned after the Boston Job Collaborative.
* Fund the Dept. of Income Maintenance budget option to increase the Medical Assistance protected income level to 133% of the AFDC standard to ensure that families and individuals with medical expenses are better off working than not working.

* Further study by the Council:
  the federal, state and local public and private sector cost consequences of adolescent pregnancy
  the state costs inherent in the provision of free day care and special transportation for school-age parents wherever public secondary education and training programs are offered
  the adequacy of daily payment limit under the AFDC-Day Care program, the number of available day care slots
  financial barriers for drop out for pregnant and parenting teens who desire to attend evening extension courses
* Keep track of the total annual and per-case health and support costs associated with women who become pregnant during their teens
* Charge the Dept. of Human Resources with the responsibility to study the cost of implementing a case-management system within its Bureau of Field Operations

Recommendations of the Policy Subcommittee:

* Institute training in family life education issues, as part of all teacher preparation courses.
* Amend the way abortions are reported through the Public Health Code.
* Formulate plans toward the creation and support of programs patterned after the Boston Job Collaborative.
* Track the total annual and per-case health and support costs associated with women who become pregnant during their teens.

The report of the Task Force lists the various state departments that would service this population, and the services currently available through these departments. The Departments are Education, Health Services, Income Maintenance, Human Resources, Children and Youth Services, Labor.

Further information may be obtained by contacting the Task Force, Room W-30, State Capitol, Hartford, Conn. 06106.

Delaware (also under Education Programs)

The program began as a pilot project in Wilmington in 1969, through a Junior League. It then became supported by the Governor, state legislators, the Departments of Health, Education, and Social Services, along with community leaders. The program is called the Delaware Adolescent Program, Inc.-DAPI. It is statewide, and a program exists in all three counties of the state.

The program is a categorical program of the Delaware Department of Public Instruction, and offers services to pregnant students in self-contained schools. After delivery, teen mothers return to their regular classrooms. Child care services, which are located near the classrooms, also serve as learning laboratories for mothers. As adolescent parents are not subject to the compulsory school attendance laws, the programs are important linkages for pregnant and parenting youth to help them complete their education.

The DAPI centers are essentially "alternative schools" for pregnant students. All services are provided in one place. DAPI owns it's own buses and transports young women to and from school in rural areas. Children may be transported with the teens on the buses, if they choose. DAPI has a strong case coordination component at the program level. The centers use a team approach to coordination, with one case manager responsible for keeping track of all services provided by different components of the team. The case management approach is sustained during pregnancy and at least one year post-partum, up to 3-1/2 years.

DAPI is the primary auspice for services, and is a non-profit corporation, governed by an autonomous Board of Directors. Pregnant and parenting students can sit on the Board of Directors, as well as the county-level Advisory Committee. The Board is composed of 20 members, consisting of community leaders, providers from fields of medicine, education, social services, and day care, pregnant and parenting teens, teen fathers, and parents of adolescents.

All public agencies cooperate with DAPI - The Department of Health volunteers lectures on health-related matters, Social Services contracts to provide services, Education provides instruction and space for the program. Each center has an Advisory Committee which advises the progam on policies and services. While DAPI is a program of the State Department of Public Instruction, it is administered by a non-profit corporation. The DAPI program serves about 500 students, and is licensed for about 83 day care slots.

The major goals of the program are to help teens deal with the multiple problems of early childbearing: school dropout, welfare dependency, medical problems, repeat pregnancies, inadequate social services, and lack of day care.

Any pregnant adolescent woman who wishes to continue her schooling in an alternative school setting is eligible for participation in the program. After pregnancy, the teen mother who wishes to return to school is eligible for services. Day care centers serve children from 1 week to 3-1/2 years of age.

The program provides social services and an educational program during pregnancy in an alternative school detting, along with the family life and childbirth education. Social Services are available for one year post-partum. Day care is available for up to three years. Other program components available during pregnancy and early years of parenting are:

Medical Care:	prenatal care; obstetrician is donated; teen women pay for own hospitalization pediatric care is available at one center; teens make own arrangements in other areas public health nurse makes visits during and following pregnancy mental health services are referred
Social Services:	individual counseling; group counseling; social services casework follow-up for one year post-partum casework and counseling for fathers and extended family as needed
Day Care:	infant/toddler care at centers by DAPI
Food and Nutrition:	food for students and babies are paid for by DAPI and USDA; 3 meals per day are given to pregnant students and mothers; babies are fed 5 times per day

Funding for the programs comes from the DAPI program budget, and from the Maternal and Child Health block grants for Delaware, which pays for day care services. Categorical funds are provided for the DAPI program through the State Dept. of Public Instruction annual budget. There are also private contributions. Title XX funds are used for day care, and DAPI participates in a federal food program. Teachers are paid by the school department. The centers are funded directly by Public Instruction, through a grant based on the projected number enrolled. There is no reimbursement mechanism, as in other programs.

A state administrative director is responsible for program development, supervision of centers, review of proposals, etc. Each center has a supervisor at the local level. The administrative director conducts routine compliance reviews and site visits. Programs must submit annual reports to the director regarding enrollments, status of participants with respect to school, subsequent pregnancies or births.

An impact study done a few years ago yielded these results:

> The study compared high school completion rates and the rate of subsequent pregnancies among program participants versus a control group of non-participants. The sample consisted of 155 treatment and 64 control individuals.
>
> * 70% of the treatment group graduated from high school; 27% of the control group completed high school
>
> * the treatment group had fewer repeat pregnancies than controls, though statistical data is not available; numbers do not reflect a significant differences
>
> * program participants were less likely to refuse birth control, and more likely to be married at the time of the second delivery

Illinois

The Illinois Department of Children and Family Services selected the Ounce of Prevention Fund to administer it's portion of the Parents Too Soon Initiative. The Fund is a public/private partnership between DCFS and the Pittway Corporation Charitable Foundation, and was established in 1982.

The Ounce of Prevention Fund is a private, non-profit corporation jointly funded by the Department of Children and Family Services and the Pittway Foundation. The fund administers a statewide primary prevention program in the state. Six demonstration programs, designed to promote healthy family functioning have been established. Through these programs, comprehensive preventive health, educational, and social services are offered to families at-risk for child abuse and neglect. The model programs were developed to address problems related to the occurrence of child maltreatment. Such problems include teen pregnancy and parenting, low birthweight infants, poor infant health, family isolation, parental psychological problems related to self-esteem, ability to cope with stress, lack of problem-solving skills. In addition, all programs include a rigorous ongoing evaluation designed to document the relationship between prevention efforts and reduction of parenting failures. The evaluation will also assess the impact and cost of such services. One of the goals of the Ounce of Prevention Fund is the dissemination of knowledge related to clinical and research issues in these areas.

The objectives of the Ounce of Prevention Fund are to prevent child abuse and neglect and other serious parenting problems. Services are ultimately aimed at reducing the incidence of child maltreatment by positively influencing those factors found to be associated with it. The Fund supports, monitors, and evaluates 28 comprehensive, community-based Parents Too Soon programs for young families and their children. Six original service demonstration sites are included. In 1984, the Fund began to offer social, recreational, educational, parent/child, health-related, employment-related services specifically for pregnant and parenting adolescents.

Services:
- Home visiting services-prenatal and postpartum
- Parenting training and support
- Child development education and modeling of appropriate parenting behavior
- Young Moms peer support groups for teen parents
- Support groups for teen fathers
- Community drop-in centers for parents and children
- Medical services, including family planning services, prenatal care, postnatal care
- Linkage and referral services not provided on-site

Parents Too Soon Program Services to participating teen's family:

- Available to teen's children, partner, parents, siblings
- Purpose to prevent too early pregnancy among other at-risk teens in target areas
- Developmental day care for infants and toddlers

Illinois

Support groups for parents of teen parents
Recreational and Educational activities for the siblings of teen parents and non-parenting teens
School-based activities focusing on responsible sexuality and alternatives to parenting
Church-based information sessions to promote communication about values between parents and children
Family Life Education
Linkage and referral for specific services as required
Emphasis on community education and involvement is stressed in all programming and networking:
Community outreach and education activities
Extensive training and involvement in service delivery
Paraprofessional training and involvement in service delivery
Volunteer training and involvement in program implementation
Establishment of community-wide service networks
Focus on enabling parents of teens and teens to translate their needs, concerns, into positive action

Program Components of Ounce of Prevention Fund: Parenting training, home visits, developmental day care, pregnancy prevention- provide activities for youth designed to be positive alternatives to early pregnancy; programs to enhance communication between parents and children regarding sexuality and decision-making.

Target Population: Preteens, non-parenting teens, other at-risk adolescents, school groups, church groups, other youth groups in community, parents of teens.

At the end of December, 1984, the Ounce of Prevention Fund's Parents Too Soon projects had actively involved 4,323 individual parents.

Parents Too Soon: The program was initiated in 1983 by Governor James Thompson in response to the severity and complexity of the crisis of teen pregnancy in Illinois. According to a report on the program, "Illinois was the first state to undertake a comprehensive effort to address the complex issues of teenage pregnancy, adolescent childbearing, and teen parenting."

Parents Too Soon funds more than 125 community-based programs. It is a network of state, local, public and private agencies. PTS is based on philosophy of comprehensive services. Three departments play the major roles in the program: Departments of Public Health, Public Aid, and Children and Family Services. The Department of Public Health is the lead agency, and is responsible for coordination among the 10 participating state agencies, as well as among local grantees.

Under Parents Too Soon, the Department of Public Health funds 3 demonstration sites, 20 family planning programs, and 17 prenatal care programs. The Department administers WIC programs, and operates the referral hotline.

Three demonstration projects provide a full spectrum of Parents Too Soon medical, social, and educational services. A fourth site opened in the fall of 1985. These programs are designed to demonstrate that the solution to the problem of teen pregnancy requires a coordinated and comprehensive service plan for each client.

In 1984, Parents Too Soon directly served nearly 21,000 youth. Another 11,416 teens were reached through community education programs and the PTS hotline provided referrals for 8,408 youth. A total of 40,682 young people were effected in some way by the programs and services in 1984. PTS serves males and females between the ages of 10 and 20.

Pregnancy Prevention Programs

Octopus: Church-based sex education programs for teens and parents. Program involves a network of health professionals, religious leaders, teens and parents in a community-oriented endeavor to promote "Open Communication Regarding Teens Or Parents Understanding of Sexuality." The purpose of the program is to prevent unplanned pregnancy with teenagers by actively involving religious leaders and parents in sexuality education of teenagers. A complete training manual is available; model is flexible for adaptation to various settings and belief systems.

Choices: The Mating Game: "Choices" is a one-hour videotape designed for group use and intended to assist young people in making responsible choices in relation to their emerging sexuality. The videotape and study guide are available.

Deep Blue Funk and Other Stories: Portraits of Teenage Parents: Book is a collection of 15 brief stories, in which black teenage parents speak for themselves about the lives they lead as adolescents, as parents and expectant parents, as daughters and sons, as students, as hustlers, as workers, and jobless workers.

Services To Promote Healthy Family Functioning and Prevent Child Abuse and Neglect:

Programs are designed to provide an opportunity for individuals who are not pregnant or parenting to gather information, obtain positive peer support, build self-esteem, improve decision-making skills; increase knowledge about parenting; engender broad community support for direct family support services, promote activities for youth in the target community in order to provide positive alternatives to early pregnancy and parenting; promote direct prevention services as alternatives to traditional treatment services; provide or obtain comprehensive services for pregnant and parenting adolescents and their families without duplication of existing community services.

Kansas

A state-level team, working closely with local health departments and community groups has developed the Kansas Youth and Families Program, which provides comprehensive services for pregnant adolescents and young parents. Eight counties were selected as program sites after 105 counties were assessed on five high-risk indicators: infant mortality, adolescent births, premature births, and two indices of fertility and poverty.

The program relies heavily on existing resources and facilities. Each county used local family planning services, and also the WIC program. Close ties are maintained with the local hospital, schools, the Department of Social Work, and other key agencies that serve adolescents.

Planning and coordination are critical to the success of the program.

The state team consists of a physician, nurse, social worker, and a nutritionist. Comprehensive services include:

- pregnancy testing
- maternity counseling
- obstetrics and pediatric services
- primary and preventive health services
- child development
- nutrition
- consumer education counseling for extended family
- social services
- family planning services and education
- educational and vocational services
- supplementary services such as child care, transportation
- adoption counseling

Effectiveness Studies

The repeat pregnancy rate with this program is 9%, compared to national rates of 25%. One difficulty being addressed is the lack of adequate day care services for infants to help aid parents to remain in school.

Maryland

The National Conference of State Legislatures report* states, "The Maryland Single Parent Services Program (Md. Ann. Code Article 6 Sections 101-103), administered by the Department of Human Resources, provides specialized services to unmarried youth who are pregnant, parenting, or at-risk of early or unplanned parenthood. Services include counseling, family planning counseling, case management services (referrals to other agencies for prenatal care, adoption, child support, employment/training, and healthy care services), and support services such as day care, aide service, or maternity home care."

In 1985, the Maryland Governor's Task Force on Teen Pregnancy issued a report that has been proposed as a model document for state policy direction. The state of Maryland has made major commitments to the prevention of early childbearing and the provision of special services to pregnant and parenting teens. The 1986 legislature authorized a $2.9 million state-funded teenage pregnancy initiative for FY87, aimed at both prevention and care.

Several agencies in Maryland have addressed the employment-related needs of teen parents. In the 1985-1986 school year, seven school districts received funds through the Perkins Act to provide services to young parents. Recipients of these grants were encouraged to combine funds with JTPA and education funds. Maryland also operates projects that target the teen parent population through the Maryland Employment Initiatives Project, coordinated by the Department of Human Resources. Programs are aimed at helping public assistance recipients to become self-sufficient through the provision of education and training services leading to employment. Projects offer an array of vocational and career-oriented activities, such as remedial education, career counseling, pre-employment training, and skills training. For younger teens, the goal is for the younger women to return to high school or obtain a GED. For older teens, work experience and job search assistance are also offered. The projects also offer intensive counseling, workshops on parenting and life skills, and support services such as day care and transportation. Projects are funded through the WIN Demonstration program, JTPA, and other state and local government funds.

* State Legislative Initiatives that Address the Issue of Teenage Pregnancy and Parenting, Natl. Conf. of State Legislatures, Denver, 1985.

For further information:

Ms. Ruth Massinga, Secretary
Dept. of Human Resources
1110 N. Eutaw St.
Baltimore, Md. 21201

Mr. John Kyle, Exec. Director
Office for Children and Youth
301 W. Preston St.
Baltimore, Md. 21201

Excerpted from: Building Self-Sufficiency: A Guide to Vocational and Employment Services for Teenage Parents, Denise F. Polit, PhD, Humanalysis, Inc., 1986.

New York

In 1985, Governor Mario Cuomo created the Governor's Task Force on Adolescent Pregnancy, and added $5 million to the $20 million the state already has for adolescent pregnancy programs for a comprehensive statewide initiative to reduce the incidence of unplanned pregnancy. The funds are to make better use of supportive services and creates new ones where needed, with priority for high-risk communities.

Through this legislation, the Adolescent Pregnancy Prevention and Services Act of 1984, five elements were brought together:

1. The targeting of resources in places with highest incidence of adolescent pregnancy.
2. Support for family life education programs.
3. Emphasis on coordination and outreach at the local level and the requirements that every state agency cooperate.
4. Grants to local agencies matched by support from the private sector.
5. Offering self-sufficiency and opportunity as an alternative to the life of an "unready" parent through employment and training programs and publicly funded jobs.

RFP's were issued for comprehensive community plans for adolescent pregnancy services and the New York Council for Children and Families of the State of New York has been given the responsibility for making decisions about funding. There is a strong voluntary coalition for family planning services with an office in Albany, that tracks adolescent issues and organizes advocacy. The Act authorized the Department of Social Services, in cooperation with the Council of Children and Families, to receive RFP's, and approve for funding, comprehensive service plans submitted by not-for-profit agencies, or county or municipal governments. These comprehensive plans would include, but not be limited to, vocational and educational counseling, job skills training, family life and parenting education, life skills development, coordination, case management, primary prevention health care, family planning, social and recreational programs, child care, outreach and advocacy, follow-up, crisis intervention, and efforts to stimulate community interest and involvement. By April, 1985, 22 organizations had been selected to receive $750,000 for primary prevention demonstration projects and outreach, training, and public awareness projects. Twenty-three applications for the $4 million Community Project Award are being considered for the final awards in that category.

A cooperative effort of the State Department of Labor and the Albany Urban League will provide self-sufficiency services for adolescent fathers who are unemployed.

The Task Force was composed of 42 members, and provided for broad-based input and a diversity of viewpoints and expertise in addressing the issue of adolescent pregnancy. The Executive Director of the Council on Children and Families chaired the Task Force, and three committees provided the necessary structure for carrying out the Task Force activities.

The Program and Policy Committees collaborated in designing two survey instruments to assess the effectiveness of current funding programs, regulations, and policies in meeting the needs of pregnant, parenting, and at-risk adolescents.

The efforts of the Task Force resulted in a new framework and direction for New York State on the issues associated with adolescent pregnancy. The Task Force proposed that New York formulate a prevention strategy that takes a more fundamental approach to addressing the causes of teen pregnancy. This approach would then impact on the capacity of basic institutions such as the educational system, local public and private sectors in the community, churches, and the medical community to promote healthy youth and family development.

Goals and Objectives

1. Develop a comprehensive state policy for addressing adolescent pregnancy which will support a balanced approach between youth and family development, and the needs of pregnant, parenting, and at-risk adolescents.
2. Support the development of programs and service models consistent with the comprehensive state policy.
3. Increase state and local awareness of adolescent pregnancy as an issue which involves and requires the commitment of all individuals and institutions.

Committees and their functions:

Policy Committee: Purpose was to establish a framework and process to guide the Task Force in policy analysis and development. Issues discussed were: educational and vocational equity for women; accessible reproductive health care; the establishment of a more effective day care policy for the state; the removal of financial barriers to service accessibility; a more aggressive youth employment policy for the state.

Program Committee: Focused on issues related to service delivery and program development. Issues discussed were: employment/vocational training and education; improved planning and program development; expanded linkages and service coordination; community awareness; increased quality of and access to health care; improved staff training and education; increased focus on services and programs for males; increased youth involvement in program development and service delivery; aggressive housing policies; greater emphasis on research and program evaluation.

Community Education and Awareness Committee: Identified the need to increase opportunities for promoting more appropriate media messages and suggested an agenda for the Task Force around community outreach and public awareness.

New York

A report of the Task Force states, "an effective prevention strategy must be anchored in a systematic network of supports and services which promote positive youth and family development. Such an approach encompasses a broad array of services and activities, including stimulating family support networks, insuring the provision of adequate nutrition and health care, and improving the availability of day care, educational and vocational services, employment opportunities and parenting education." The report further states that past efforts have not traditionally viewed youth and family development as primary prevention strategies to address teen pregnancy. Efforts have been frequently initiated too late, often after the youth have already initiated sexual activity, or become pregnant. "Youth must be given hope for the future and realizable options and opportunities if they are not to become parents by default."

An important goal of the Task Force, with regard to youth and family development is to encourage a broader application of youth and family development strategies across youth issues and concerns. Among the tasks outlined to facilitate achievement of the objectives are:

a. to delineate the relationships among the various problems experienced by adolescents and their families such as juvenile delinquency, drug abuse, alcohol abuse, etc.

b. encourage the development of demonstration efforts which seek to concurrently address a variety of problems through a youth and family development framework

c. develop recommendations for a funding strategy to support the expansion of such models

An initial report of the Governor's Task Force on Adolescent Pregnancy, "Setting Directions", was published in February, 1985. The report describes the goals, objectives, and activities of the Task Force, and outlines an agenda for 1985 and subsequent years. The report provides a framework for developing a comprehensive approach to adolescent pregnancy in New York State.

The second report of the Task Force, "Moving Forward: Next Steps", identifies gaps in services and existing barriers to these services, and outlines a series of specific recommendations to achieve the goal of reducing teen pregnancy and its associated problems.

The report, published in January, 1986, states that New York experienced 59,000 teenagers under age 20 becoming pregnant in 1984. In that same year, 29,000 teens in the same age group became parents.

The report outlines prevention strategies focusing on youth and family development, and provides a framework for policy and programming recommendations that are multidimensional:

Dimension I: Involves two major directions: focus on youth and family development; a comprehensive, coordinated approach to services for pregnant, parenting, and at-risk youth.

New York

Dimension II: Outlines crosscutting issues to which the Task Force is philosophically committed; includes such issues as empowerment of families, communities and individuals; accessibility and equity of services; and service coordination.

Dimension III: Focuses on major service areas which relate to adolescent pregnancy; areas are child care, health, housing, education, employment and income support.

The report states that there has been insufficient emphasis on youth and family development. "Within the constraints of limited resources, human service systems tend to serve those most in need (i.e., those in states of crisis, or those least able to cope). This delayed approach to services, combined with a lack of understanding of the long-term fiscal benefits of prevention, has hindered efforts to develop a systematic network of supports and services which promote positive youth and family development."

The report identifies gaps and barriers in the servicing process:

Education: To dropouts, school is viewed as dispensable and irrelevant to their futures.
Mandated family life education programs are recommended.
Comprehensive school-based clinics should be expanded, and extended.
Education should be provided in a caring. nurturing setting.
Youth should be encouraged to explore interests and potential, while ensured that they receive basic skills.
Education programs should promote a broader range of skill development related to social responsibility, values and decision-making.
Academic achievement alone can not be over-emphasized, thus creating a barrier if standards are too high. Physical and social needs must be addressed. Youth competencies should be enhanced.
Schools need support services integrated for a holistic approach.

Health: Adolescents perceive health services often as "unapproachable".
Services need to be provided within the ethnic and cultural context of the population targeted for services and therefore are not seen as familiar and comfortable for minority youth.
Foster healthy socio-emotional development of the individual and bolster the ability of families to raise their children.
Remove barriers to health, family, or mental health problems that impede ability to learn.
The ability of youth to succeed in school and become self-sufficient and productive members of society rests to a large extent on adequate nutrition, the detection and treatment of medical problems, provision of preventive health services, health education and reproductive health care.

New York

Health: The effectiveness of any one service is often dependent on the degree to which it is linked to other services which the client needs.

Employment/Training: Current programs have proven to have limited effectiveness in helping pregnant, parenting, and at-risk youth.
JTPA, the major vehicle for employment/training, presents a number of barriers for the entire at-risk population, among them performance standards set up by the federal government, and child care.
There must be a fundamental commitment to youth and family development, providing hope for the future, and realizable options and opportunities.
For pregnant and parenting teens, the transition from public assistance to employment is fraught with setbacks, often associated with a lack of adequate support services, inadequate health coverage, and safe, consistent child care.
Vocational training and subsequent employment are essential for young people to become self-sufficient.
Training and employment strategies must result in jobs with adequate salaries and promotional opportunities.
All adolescents should be provided with the skill and opportunities to make an adequate living for themselves and their future families.
A statewide employment policy is recommended, with specific services targeted to at-risk, pregnant and parenting teenagers.
The use of youth employment competencies under JTPA should be encouraged and expanded.
The Dept. of Labor should encourage, through its local planning process, the development of local partnerships between community-based organizations serving pregnant and parenting adolescents and JTPA-funded employment programs.
The STEP program (see Education Section) should be expanded to include a specific component of the program targeted to pregnant and parenting adolescents.

Independent Living: Available role models are inadequate.
Formal curricula for preparing youth for Independent Living are rarely found in education settings, or in residential settings.
In addition to basic housing shortages, there is also a scarcity of support housing models to meet the needs of pregnant and parenting teenagers.
A continuum of appropriate living arrangements should be available.
Federal changes in public assistance regulations should be assessed, and recommendations developed to remove federal disincentives.
Shared housing should be encouraged.
Funds should be made available to demonstrate model housing arrangements for pregnant and parenting adolescents.
Housing strategies that bring together elements of employment and training and private/public cooperation should be encouraged.

New York

Child Care: On site child care provides an integrated approach for this population.
Child care should be interwoven with parenting education.

Family Planning: There is a substantial unmet need for preventive reproductive health care for adolescents.
There is a strong correlation between accessible, affordable, and confidential family planning education and services, and reduced rates of adolescent pregnancy, abortion, and births.
Funding should increase for basic family planning services.
Satellite clinics should be established in hard-to-reach areas.
Weekend and evening clinics should be established.
Linkages should be established between schools and other community-based youth servicing agencies.
The needs of adolescent males should be addressed.

Wisconsin

In November, 1985, the Wisconsin State Assembly enacted Bill 510, Wisconsin Act 56, "Abortion Prevention and Family Responsibility Act of 1985". The Act lists legislative findings, including numbers of teen pregnancies and abortions, the need for health services and other programs, which must be multi-faceted, the need for programs to enhance self-esteem, decisionmaking, etc., the consequences of early pregnancy, especially abortion, the promotion of programs that enhance life options, and other specific findings.

Provisions of the legislation are as follows:

A. Creates an appropriation for grants to adolescent pregnancy prevention programs and pregnancy services to reduce the incidence and adverse consequences of adolescent pregnancy.

B. Requires school districts to offer a human growth and development program, but allows school districts not to teach certain components of the program, and allows parents to exempt their children.

C. Expands the current School Age Mothers program to be a School Age Parents program.

D. Creates a state adoption center to increase public knowledge of and promote the availability of adoption.

E. Prohibits trespass to medical facilities.

F. Requires grandparents to support the children of their minor children.

G. Requires group health insurance policies to provide the same level of

Wisconsin

maternity benefits to all persons under the policy.

H. Requires women, prior to obtaining an abortion, to be provided with specific medical and other information, and to give their informed consent to the abortion.

I. Revises the current criminal law on abortion to be consistent with the constitutional requirements of Roe vs Wade.

J. Repeals current restrictions on advertising and displaying non-prescription contraceptives and on who may sell nonprescription contraceptives.

The Legislative Council established a Special Committee on Pregnancy Options, which studied ways to:

1. make information available within the present constitutional framework

2. provide more funding for family planning options other than abortion

3. requires all school guidance counselors, social services, physicians and family planning clinics to prominently display pamphlets about adoption

4. make available insurance coverage for childbirth in all instances

Provisions of the bill also include family life education, parenting education, human sexuality, reduction of sex stereotypes and improved protective behavior, aid to schools for parenting education, coordination with existing vocational job training in the school district, and other services. Adolescent fathers are encouraged to participate in programs.

Children's Defense Fund

CDF was founded over a decade ago by Marian Wright Edelman to focus the nation's attention on the plight of disadvantaged children, and to develop an advocacy for programs and funding support. CDF conducts and publishes research studies and findings, program evaluationa nationally, publishes a newsletter and reports, and other activities. For the past several years, CDF has focused on teen pregnancy, especially on minority youth, economic opportunities and life options programs. motivational factors influencing decisions making in teens, and other initiatives.

The Children's Defense Fund fosters large-scale community-based efforts organized and supported by national organizations, and sometimes federally-funded. CDF acknowledges the importance of sexuality education and access to family planning, but concentrates also on life options interventions through schools, churches and industry, and personal one-on-one support programs.

Joy Dryfoos lists the efforts of CDF in her research: [167]

1. consciousness-raising with major black women's groups and religious constituencies

2. sharing information and models encouraging a range of new outreach, role modeling, direct services, and demonstration projects

3. gathering and disseminating relevant research and information

4. implementing new public policy analyses in CDF's program areas; helping adolescents stay in school, gain skills and jobs, get needed health information, get services to bolster self-esteem and self-sufficiency

5. systematic attention to the media and its messages to adolescents

In conjunction with four major national organizations and their local groups, CHILDWATCH was launched, with teams recruited from 60 local areas around the country. The four groups are the Association of Junior Leagues, the National Council of Negro Women, the National Coalition of 100 Black Women, and the March of Dimes Birth Defects Foundation. The groups will conduct needs assessments, monitor the availability of services, analyze policies, give feedback information to the national office of CDF, and participate in advocacy for funding, programs, legislation, and other activities.

The National Urban League, Inc.

The Urban League is involved with large-scale community-based initiatives. Concentration and emphasis of the efforts of the Urban League are also focused on life options programs, and programs to enhance the opportunities and motivation of disadvantaged youth. It is particularly interested in programs targeted to males. Involvement with local community groups, churches, business and industry, schools, and one-to-one support groups is heavily emphasized.

The Urban League has developed a network of primary and secondary prevention programs called the Affiliated Development of Adolescent Pregnancy Programs (ADAPP). Using a Mott grant, the Urban League supports

services aimed at preventing pregnancy or easing its consequences among minority youth served by 10 Urban League affiliates.

Center for Population Options

The Center was organized by Judith Senderowitz in 1980, with a focus of helping adolescents make informed parenting and career choices, thereby alleviating profound negative social, health, economic, and demographic implications. Douglas Kirby is the current director of CPO.

The Center conducts research, issues publications and information, statistical data, and reports regarding pregnant and parenting teens, and in associated areas.

Foundations

The Too-Early Childbearing Network (TEC)

Through the TEC, a network of the Mott Foundation, the projects share information and experiences both formally and informally. The seven projects are:

Parent Infant Interaction Program, St. Louis
CYESIS, School Board of Sarasota County, Fla.
Teen Parent Assistance Program, Oakland,Calif.
Teen Parent Family Support Project, Alliance for Young Families, Boston, Ma.
Monroe County Adolescent Pregnancy Preventive and Supportive Services Program, Rochester, N.Y.
Comprehensive Adolescent Health and Education Program, Corpus Christi, Texas
Teen Indian Pregnancy and Preventive Services, Seattle, Wash.

The Women and Foundations/Corporate Philanthropy Program

The program co-sponsors local conferences on teenage pregnancy with other grantmakers. The Mott Foundation has a cooperative venture with the Michigan Dept. of Social Services and WAF/CP whereby 27 communities have developed comprehensive plans to address the problem of teenage pregnancy.

Robert Wood Johnson Foundation

The RWJ Foundation is involved in channeling money into pregnancy prevention education and research projects. The Foundation is currently funding the School-Based Adolescent Health Care Project, an outgrowth of the foundation's School Health Services Program and Program to Consolidate Health Services for High Risk Young People. Twenty diverse programs have been funded in needy areas, to improve health services. A major goal of the RWJ foundation is to accelerate the adoption of school-based programs in communities and schools on a national scale. Each program will offer a comprehensive range of services for young people in one or more public schools. The school sites will be for primary care health center projects.

Since 1981, the Foundation has funded research projects in such areas as the effects of teenage pregnancy and the effectiveness of intervention strategies.

Ford Foundation

The Foundation is supportive of research and training in reproductive sciences and contraceptive development since 1959. The foundation supports university-based population studies, and coordinates efforts of related private organizations and public agencies. The Foundation provides support for programs, projects and research, training, institutional development, and makes periodic reports of interest to those working in the field. It has a primary objective towards global efforts in the facilitation and development of contraceptive methods through the funding of basic and applied scientific research. The Foundation contributes to the development of new and pre-existing institutions, and attempts to facilitate communication and cooperation.

Charles Stewart Mott Foundation

The Foundation has given the Urban League grants for 10 teen pregnancy projects. Grantees had to participate in the Too Early Childbearing Network, for evaluation and research data gathering systems designed and operated by Mott contractors. The Foundation received funding from the federal OAPP for 5 affiliated programs.

Since 1976, the Foundation has invested almost $4 million in the area of adolescent pregnancy, and has been involved with this issue since the 1930's. The Foundation's interest in adolescents includes programs dealing with maternal and child care as well as family life education. Grants have been given to networks to design accountability systems. The Foundation focuses simultaneously on the amelioration of the negative effects of teen pregnancy once it occurs, and on primary prevention through replication of a low cost, school-based model for high-risk youth. Programs have received funding to conduct research on adolescent sexuality, evaluation of model treatment programs, and to conduct conferences on teenage pregnancy prevention.

Carngeie Corporation

Funds programs dealing with children, and funds programs on adolescent pregnancy. The Corporation has spent approximately $1.3 million on programs aimed primarily at delaying first pregnancy among adolescents. Carnegie is particularly interested in programs initiated by national organizations and targeted at adolescents 15 and younger.

William T. Grant Foundation

The Foundation funds research into the problem of school-age children, and began making grants available for teen pregnancy prevention about five years ago. Most grants have been for research and evaluation on the effectiveness of intervention programs. The Grant Foundation has spent approximately $2.1 million in the area of school-age pregnancy.

The Harris Foundation

For over a decade, the Harris Foundation and the Pittway Corporation Charitable Foundation, of which Louis Harris is chairman, have supported programs to address the problem of teenage pregnancy. The Foundation has funded the Ounce of Prevention Fund in Illinois, and have funded the planning and development of two school-based adolescent health clinics. Pittway has provided significant operating support for the first of these two clinics.

In the 1970's, in response to programs that were "fragmented, inefficient, and inadequate", comprehensive care programs became the preferred approach for assisting the target population, many of whom come from severely economically disadvantaged backgrounds.[168]

Hofferth, (Vol. II: Ch. 9), as listed in Risking the Future, gives descriptions and findings of several of the most visible comprehensive care programs:[169]

* Project Redirection, supported jointly by the Ford Foundation and the U.S. Department of Labor and evaluated by the American Institute for Research and the Manpower Demonstration Research Corporation.

* The Too Early Childbearing Network, supported by the Charles Stewart Mott Foundation, evaluated by Deborah Walker of Harvard University and Anita Mitchell of the Southwest Regional Laboratory.

* The Adolescent Family Life Comprehensive Care Projects supported by the federal Office of Adolescent Pregnancy Programs and evaluated by the Urban Institute.

* The Adolescent Pregnancy Projects, also supported by the OAPP and evaluated by JRB Associates.

* The Young Mothers Program, operated by the Yale-New Haven Hospital and evaluated by Lorraine Klerman, then at Brandeis University, and James Jekel, then at Yale.

* The Prenatal/Early Infancy Project, operated by the University of Rochester School of Medicine and evaluated by the program staff.

* The Johns Hopkins Adolescent Pregnancy Program, operated by the Johns Hopkins University Hospital and evaluated by the program staff.

* The St. Paul Maternal-Infant Care Program, operated by St. Paul Ramsey Hospital and evaluated by the program staff.

* The Rochester Adolescent Maternity Project, operated by the University of Rochester School of Medicine and evaluated by the program staff.

Program descriptions and evaluation research conducted on the programs are presented throughout this report, with some descriptions on the following pages. Some findings of reviews of these programs indicate:[170]

* There was evidence of positive, short-term effects in areas of concentration.

* Long-term positive effects have not yet been demonstrated.

* While clients have been shown to do well while in comprehensive care programs, their later health, education, and employment outcomes are less positive.

* Those who remain in programs longer appear to do better than those with shorter services.

* There is some evidence that those in comprehensive care may do better when they are youth with the greatest needs.

* Among programs that rely on a brokerage model, the quantity and quality of services depends on what is available in communities.

* There is some evidence that pregnant and parenting teenagers may require a different mix of services depending on age.

* Comprehensive care services can be costly.

* Comprehensive care programs as models are based on an assumption that essential resources exist at the local level:
  - basic health, education, and social services and funds to operate them
  - political and popular support
  - clients
  - effective interventive technology

The following pages contain brief descriptions of comprehensive, multiservice programs across the country. Research evaluation data is stated from whatever programs had such information. Sources for information on each program are reports obtained by the Task Force from the program staff, or program director. Reports and program descriptions are titled under each description.

San Francisco, California, Teenage Pregnancy and Parenting Program (TAPP)

TAPP is based in a private non-profit Family Service Agency. Program components include comprehensive care, continuous case management, and co-location of service providers for expectant and parenting adolescents. The major program goals are: 1. to improve the health of the infants born 2. to improve the school continuation of the adolescent parents 3. to reduce the repeat pregnancy rates.

In the first four years, TAPP enrolled 592 pregnant females and 72 expectant males who were less than 18 years old and had not graduated from high school. Case management includes continuous individual counseling and coordination of educational, psychosocial and clinical services. Home visits and consultations with family members about problems are a regular part of the continuous counseling. Through federal funding, the program is able to offer services for up to three years after the birth of the baby.

A Pregnant Minor Program school is located at TAPP, where teens can continue schooling from the time the pregnancy is determined until the completion of the semester in which the baby is born. The school has a specialized curriculum to meet educational needs, and the unique needs of pregnant teens. The curriculum includes nutrition, preparation for childbirth, infant care and parenting skills.

Data was collected from each participant upon entry, at childbirth, and six months later. The measures of the survey conducted were: school enrollment at each milestone, school continuation between milestones for those enrolled in school at any milestone, and school re-enrollment between milestones for those not in school.

Results of the survey:

- school enrollments did not decline, but rose after entering the program
- there are certain groups that are expecially at-risk for discontinuance of school during key life transitions and should be considered high-risk clients for case management
- risk factors during pregnancy include being older than expected for grade level, being married or living with partner, 9th and 10th graders are at risk for dropping out, not being in school at entry, being a Latina, having been out of school for more than 4 months and not having part time employment
- clients who received a greater number of counseling service hours had higher rates of school continuation and re-enrollment
- after-birth risk factors included being older than expected for grade of enrollment, not having childcare outside the family
- clients who received a high number of postnatal hours of services were significantly associated with school continuation and re-enrollment

"Evaluation of School Continuation of Teens in the San Francisco Teenage Pregnancy and Parenting Program", "Expectant Females and Male Adolescents through the Six Month Postnatal Milestone". Institute for Health Policy Studies, U. of Calif. San Francisco. Amy Loomis, Director of TAPP.

Minnesota, Minneapolis-St. Paul, Minnesota Early Learning Design (MELD) Young Moms (MYM)

The MYM program began in 1978 with funding from the Carnegie Corporation of New York, and a year and a half of research and exploration. The pilot began with two groups in the Twin Cities in 1979.

The Young Moms Program of MELD is a comprehensive, two year program that provides young mothers with the information and psychological support they need to survive and progress during a life-threatening crisis. Since the program lasts two years, it can significantly impact the life of the mother, child, and in some cases, her siblings.

The program is a primary prevention program that intervenes in the life of the mother during pregnancy and throughout the first two years of the life of the child. Efforts are made to prevent abuse and neglect, develop a solid foundation for the mother-child relationship and maximize the child's developmental capacity.

The program focuses on the family system, and equips the mother with needed and timely information and decision-making processes that will help ensure responsible reproduction and parenthood.

Group discussions and curriculum presentations focus on preventive health concepts, family planning information and nutritional guidelines. Child development and child guidance concepts are reinforced so that mothers will develop realistic expectations for their children's behavior.

Teens are encouraged to complete their education and career goals through taking responsibility for their own lives and helping them identify their life goals and plans. Basic practical instruction is provided.

MYM has site coordinators to coordinate services for four MYM groups at each location. They are responsible for implementing, maintaining, supporting, supervising, training and evaluation of the MYM programs at a site. The programs have many volunteers.

A community sponsor is an agency that provides funding and publicity for the MYM program, employs a site coordinator, and assists with program management and administration. Cosponsors are usually social services, health or educational programs that provide or arrange for the following services: meeting space, transportation, childcare, food and social services.

Each MYM group is facilitated by two carefully screened and selected single women who became single mothers in their teens. They are peers by experience rather than age. The program uses the peer self-help approach- experienced moms helping other young moms.

The program serves adolescents from 12 to 22 years. Mothers are clustered in groups according to age and the ages of the babies. Many change their housing situations frequently. They are mobile, high risk, often out of school, poor, struggling adolescents with babies.

In September, 1982, the National Center on Child Abuse and Neglect awarded a grant to the Minneapolis Public Health Dept. to install a program within their agency, and the Ford Foundation awarded a grant to the Child Welfare League of America to research effectiveness. Additional grants were received from Gulf+Western Foundation, the State of Illinois and the Ounce of Prevention Fund. The program is now operating in Arkansas, Colorado, Georgia, Illinois, Iowa, Minnesota, Missouri, North Carolina, Ohio, South Dakota, Texas and Wisconsin.
MELD, 123 North 3rd St., Minneapolis, MN 55401, 612-332-7463

New York, New York, The Door-A Center for Alternatives

The Door is a multi-service, community-based center for adolescents between the ages of 12 and 20 in New York City. Programs are after school and in the evening, and are low cost, or free. The approach is holistic, and accounts for the physical, emotional, intellectual, and interpersonal dynamics of the person. General development, health, family planning, mental health, education, employment, vocational information and referral, and self-development activities are offered. Creative and rehabilitative workshops in arts, crafts, poetry, music, theatre, and dance, as well as gymnastics and other recreational arts programs are sponsored by the Door. A learning center, youth leadership program, drug and alcohol abuse treatment programs, young parents and child health series, and psychiatric treatment program are all ongoing structured services.

The Door's goals are to prevent teenage pregnancy by conducting discussions of sex roles and behavior, pregnancy, values clarification, and decision-making.

Special family programs for physically handicapped adolescents, very young adolescents, male adolescents, and adolescents who have already experienced a first pregnancy have also been developed. Direct outreach and sex education programs are also done in local schools.

The Door services 200 clients a day, with the average age of 16 years. In 1985, the family planning programs served 3,400 teens, with 13,441 visits. 79% were young women, and 21% were young men. 90% of the young women served were at or below the poverty level.

The Door also consults with other youth serving groups and agencies and parent groups, and provides training.

The Commonwealth Fund evaluated the Door program from July 1981 to June, 1983. Findings are that 21% of the sexually active teens used contraception before entering the program, while 87% practiced birth control after being exposed to one or more of the Door's family planning programs.

The Door-Center for Alternatives, 618 Avenue of the Americas, New York, N.Y. 10011, 212-691-6161.

Excerpted from Children's Defense Fund, "Model Programs: Preventing Adolescent Pregnancy and Building Youth Self-Sufficiency.

New York, New York, Multi-Service Family Life and Sex Education Program, Dunlevy-Milbank Children's Aid Society Center

Program was begun by Michael Carrera, a leading sex educator and professor of health science at Hunter College. It is multi-dimensional, and is aimed at teens, preteens, and their parents, and is based at the Children's Aid Society Center. The program is wholistic, and integrates sex education in the context of a variety of other services. Mr. Carrera believes that single intervention programs do not effectively influence the behavior of teens.

Nearly all dimensions of the program that the children experience, are also experienced by their parents or other significant adults, in a separate but parallel track. Confidentiality is thus protected, with parents still participating.

There are five core programs, beginning with Family Life and sex education. The program links sexuality to body image, gender roles, social roles,

feelings, relationships, intimacy, and other issues that require looking at the larger picture of a whole person.

Students graduate after a 15 week course, helping to build self-esteem. It includes-diplomas, speeches that stress having mastered something, self-worth and achievement.

Youth are also involved in individualized sports such as squash, tennis, golf, and swimming. Strengths from these sports will hopefully be transferred to other non-athletic aspects of their lives.

A third component is Self-Expression, which involves teens in weekly workshops with actors and actresses from the National Black Theatre. Self-expression and motivation are explored. Plays are performed, with roles stressing decision making, caring for another person, tenderness as a man, and responsible behavior.

The Job Club has youth participating in weekly career awareness and job preparation classes. Graduates are assured of summer jobs. Youth receive full academic assessments. A teacher does individual tutoring and provides help with homework, based on the individual profile.

The final dimension involves health and medical services. Two pediatricians, who are adolescent specialists, and a nurse staff the medical office within the community center. Clients receive a thorough exam and long consultation period with doctors, to complete a health profile. A full time health worker arranges weekly visits with at-risk youth.

All services operate simultaneously, five days a week, from 3:30 to 9:00 p.m. All services are free.

The first year, the program served 66 youth and 29 parents. 34 were males. Since the program began, there have not been any further pregnancy, and to the knowledge of the staff, no males fathered a child.

The program is funded by a $60,000 grant from the New York State Division of Social Services, from private businesses and donations, and from an open-ended allocation from the Children's Aid Society.

A parallel program is being operated in East Harlem in a bilingual setting. Dunlevy-Milbank Children's Aid Society Center, 14-32 West 118th St., N.Y., N.Y. 10026, 212-369-1223

The Hub, Bronx, New York

The staff decided it was important to locate services in the same building, and to have a network in place in the same location. Important components are helping to motivate teens, educate them, and access them to services. Teen clinic has flexible hours, adapted to the schedules and daily lives of the teens. Literacy skills of the teens are given much attention, as this is felt to be a critical need. Competency building and learning to be self-sufficient are important elements in the program.

Teens were invited to participate in the development of the program, and add their input to the life options component of the program. Inner city youth stated that they would like to have many of the things at the center that other suburban youth had in their lives. Parents were also included in the development of the program. Most youth stated that they wanted a place to go, where they could talk with adults and other youth about problems; a place that was safe, and where they could go to get off the streets and get help.

The program has a streamlined referral system, so access to services is facilitated early, and communication with other agencies is open.

Areas worked on with the youth are in the development of a work ethic, and positive attitudes towards work, study, etc. Problems to be dealt with here are that staying in school and finishing does not always guarantee a good job.

The program works on areas of personal growth and development, so that youth will feel they can accomplish goals. They need to have positive role models, and to develop positive roles and identify positive roles for themselves. Skills building is a critical component in the program, along with assertiveness training. One of the concerns expressed by the youth is date-rape, a common form of sexual assault among teenagers.

According to staff members, the perceptions by the teens is that having a child is a positive reward when other options are not open. Setting and achieving goals in the real world involving school attainment, career choices and fulfillment, self-sufficiency, etc., are difficult to attain, especially for disadvantaged youth. These perceptions of the youth are often difficult to change.

Staff also say that many teens have "needs behind needs"- the underlying needs being the real ones that need to be addressed, such as motivation, attention, nurturance, and lack of belief in self.

Peer educators are crucial in service delivery and discussion-counseling services.

The program developed several years ago and originated in a hospital setting, with a Planned Parenthood Center in the setting. The program is a comprehensive pregnancy prevention program. The youth have also identified sex and drugs as major problems in their lives.

New York, Project Redirection

Project Redirection was begun in 1980 in four sites, with support from the Ford Foundation and the U.S. Department of Labor. Through the Manpower Demonstration Research Corporation, the Project worked with hundreds of pregnant and parenting teens in 7 different communities, in attempts to help teens with development in personal relationships and economic self-sufficiency.

Teen mothers were assisted by professional staff in the attainment of health education and employment services they needed. Volunteer role models from the community help the youth set goals and pursue ways to achieve them, through school counseling, health care, and family planning. Comprehensive services are offered, directly or by referral, to support pregnant and parenting teens in participation in education, job training and employment programs.

An evaluation of Project Redirection, a two year demonstration program, shows that teenagers from a comparison group, who were not enrolled in the demonstration program, were significantly more likely than project participants to experience a repeat pregnancy after one year, but after two years the difference was small and nonsignificant. At 12 months into the program, the project participants proved more likely to be using contraceptives, but by 24 months the comparison group had caught up.

After one year, the project teenagers were more likely than the others either to be in school or to have graduated, 56% and 49% respectively. This differential disappeared after 24 months. Project teenagers who had dropped out prior to joining the program and those who had a repeat pregnancy were more likely to be in school or to have completed school than were similar comparison teens. Project

teens were also somewhat more likely to have held a job during the two year period than were teenagers not enrolled in the program.

The evaluation demonstrated that teenagers who participated in the project and remained in it for more than a year had consistently better outcomes in education, employment and repeat pregnancy than any other group had. Comparison teens who had never participated in any special program for pregnant teenagers, demonstrated consistently poorer outcomes than any other group.

The program evaluations stated that teen fathers are generally ignored in services, as are the family members of teens, who often were a source of housing, financial assistance, child care, emotional and other forms of support. However, families may also be a source of conflict, neglect, poor modeling behavior. Family circumstances are important intervention points.

Sources: "Project Redirection: Evaluation of a Comprehensive Program for Disadvantaged Teenage Mothers", Denise Polit and Janet Kahn, Family Planning Perspectives, 1985. "Choices and Life Circumstances: An Ethnographic Study of Project Redirection Teens", Manpower Demonstration Research Corporation, June, 1983. A thorough evaluation report that discusses all aspects of the Project and the research conducted. Comparison groups were taken from matched cities in the U.S., compared with the teens receiving the program. Harlem, a program site, was paired with Bedford-Stuyvesant; Phoenix with San Antonio; Riverside, Calif. with Fresno; and Boston with Hartford.

Franklin, North Carolina, Early Start, Appalachia

The program is a comprehensive approach, utilizing the professional services of several agencies. Family educators are an integral part of the program. Staff members will try to find housing, chauffer mothers to a picnic, coach a young woman through labor. The program begins soon after a teen learns she is pregnant. Expectant mothers 17 and younger are given priority, regardless of income. Most teens have dropped out of school due to financial strain. In this rural Appalachian community, geographical isolation adds to their loneliness. Often the youth have no friends, no telephone, or transportation.

The program was begun by Lois Sexton, who is director of Head Start for the Macon Program for Progress. She designed the Early Start program to help young parents give their children a solid start in early life. Initial funding came from state and federal grants, but the program exists now on state funds alone. The program is now in it's 5th year. Early marriage is a cultural norm in this area of the country.

The program has three family educators, whose job it is to work closely with clients through pregnancy, childbirth, and the children's first three years.

Early Start (ES) has five basic components: home visits, exercise classes, group sessions, parenting classes, and classes in which craft items are made to sell. The program has 60-75 clients at any one time. After the child's birth, the young mothers are taught how to nurture their children, understand their development, and to play with their children. Many finish high school, or obtain a job, and confidence-building is a goal. During preliminary evaluations, no new cases of child abuse occurred, and fewer premature births. There is a low level of repeat pregnancies, 3 at a year's period. ES helps young mothers to gain control over their lives and make responsible decisions.

PROGRAMS AND SERVICES: COST COMPARISONS

In her recent book, Families in Peril: An Agenda for Social Change, Marian Wright Edelman, President of the Children's Defense Fund, gives a comprehensive cost-effectiveness breakdown of providing preventive programming to children and youth. As prevention of teen pregnancy, and other problems experienced by youth begins often in early childhood, it is useful to present these breakdowns in this report:

1. It costs $47 for a complete set of immunizations for a child. It costs an estimated $25,000 per year to keep a mentally retarded child in an institution. The U.S. saved an estimated $1 billion in the first decade of measles immunization efforts.

2. It costs $600 to provide comprehensive prenatal care and have healthier babies; it costs more than $1,000 per day to keep low birthweight babies alive through meonatal intensive care.

3. It costs an average of $40 to provide a child the needed preventive checkups for an entire year under Medicaid; it averages $600 daily to hospitalize a child for an illness that could have been diagnosed and treated without hospitalization if there had been a routine preventive checkup.

4. It costs $2500 to give a child a year of Head Start or $3000 to provide day care which enables a mother to work. It costs $4200 to provide a year of AFDC benefits to a mother unable to find work or pay for day care.

5. It costs $68 to provide family planning services to sexually active teen; it costs $3000 to provide that teen and her baby prenatal care and delivery costs under Medicaid.

6. It costs $600 to provide a year of compensatory education services to a teen; it costs more than $2400 to finance a repeated grade for a disadvantaged student.

7. It costs $495 per year to provide infant care through the Supplemental Food Program for Women, Infants, and Children (WIC); it costs an average of $12000 to save a newborn with neonatal intensive care.

8. It costs $7300 to provide a mother and two children with AFDC, housing assistance, food stamps, and energy-assistance benefits at 80% of the poverty level; it costs $8000 to fund those two children in foster care when that mother becomes homeless or her home heatless.

9. It costs $1100 to provide a summer job for a teen; it costs $20000 to keep that teen in a juvenile institution for a year.

The Alliance for Young Families also gives some costs for programs that prevent many social and economic problems with youth:

Cost of a peer support group program per year for each youth:	$120
Cost of career preparation/job exploration program per youth:	$ 60
Cost of comprehensive health care program, either community-based or school-based clinic for each youth	$200-$250
Cost of comprehensive services through a life options center for teens for each youth	$440

Other costs of programs and services needed by pregnant and parenting teens are:

Estimated cost for providing ET services to pregnant and parenting teens	$3100
Cost of quality day care services for infants and toddlers and their teen parents for a year can be up to	$10,400
Costs of AFDC for a teen and infant, depending on housing situation can range from	$ 4,728 to $ 4,908

An article in State Government News states that it costs $2300 a year to provide special services to keep a child safely at home in a troubled family. It costs about $4,000 a year to maintain a child in foster care and $16,000 or more in an institution.

Pregnancy and childbirth during the teenage years involves more significant risks than for women over 20 years of age. Teenage women have twice the normal risks of delivery complications than do older women. Teenagers who become pregnant and give birth early in their teen years are likely to have twice as many children as do older women, thus causing further risks and potential complications. For younger teens, 15 years and under, pregnancy and childbirth poses serious health risks.

Pregnant teenagers are 15% more likely to have toxemia, 92% more likely to have anemia, and are 39% more likely to have complications related to premature births.[171]

A recent Massachusetts report stated, "complications of pregnancy and delivery, low birthweight, and infant mortality are associated with poor nutrition, smoking, substance abuse, and inadequate prenatal care."[172] Pregnant teenagers, as a group, have one or more of these characteristics with predictably poor outcomes for the newborn and the mother.

Teen mothers are more likely to die of pregnancy-related health complications than are older mothers. The maternal death rate for younger teens giving birth is two and one-half times the rate of older women. The mortality rate for black women is three times higher than for white women.[173]

In the United States, 10 out of every 25 pregnant teenagers deliver their babies by cesarean birth. The rate of teenagers under 15 years having cesarean births in 1984 in Massachusetts was 17.9 per 1,000; for those teenagers 15-19 years, the rate in the same year was 14.2. Teenagers under 15 years had 15 cesarean births in 1984 - all primary births. Teenagers 15-19 had a total of 985 cesarean births in 1984, 870 being primary, and 115 being repeat cesarean births. Of the 7,016 births to teenagers in 1984, 1,000 were cesarean births, or 14% of all teen births in that year.[174]

Many teen mothers, and teenagers who become pregnant, are also involved in drug and alcohol use and abuse during their pregnancies, and after the births of their children, thus passing on many health complications to their infants and children. Further discussion of drug and alcohol use among pregnant and parenting teenagers can be found in this section under the Department of Public Health's MAPPS study.

A report on Title V, Maternal and Child Health Services, by the Department of Public Health, states, "maternal and child health status among minority populations is poorer than that of the general population, in large part due to restrictions on access to health care because of cultural, racial, and economic barriers. Much of the difference in health status between whites and minorities can be explained by economic variables."[175] For those individuals and families whose incomes are at or near the poverty line, the maternal and child health risks are even greater. Many of those who are most at-risk, are teenagers and their children. There are many unattended health problems among low income and minority pregnant teenagers. Marian Wright Edelman, in Families in Peril, states, "because of greater poverty, many young black mothers are at significantly greater risk of poor health, and many enter pregnancy at reduced health status."[176]

Prenatal Care

Results of a survey in 1984 in all fifty states[177] indicates a definite

shift away from early prenatal care to late or no prenatal care among pregnant teenagers. It has been consistently documented that babies born to women receiving late or no prenatal care are three or more times as likely to die in infancy as those receiving early care.

A national study on the prevention of teen pregnancy states, "young mothers are the most in need of comprehensive prenatal care, yet are the least likely to receive early care during pregnancy."[178] According to the Children's Defense Fund[179] only 33% of pregnant teens under age 15 begin care early in their pregnancy, and only 54% of pregnant teens ages 15-19 receive early care. During the first three months of pregnancy, 56% of teens do not receive prenatal care; for pregnant teens under 15 years, one in five receives late or no prenatal care, according to a national report.[180] From this same report, nearly 40% do not receive any prenatal care until the third trimester of their pregnancy.

According to national data, for white teenagers, ages 15-19 years, 57% receive early prenatal care. For black teenagers in the same age group, only 47% receive early care.[181] For those pregnant teens under 15 years, 32% of black teens receive prenatal care in the first three months; 36% of white teens under 15 years receive prenatal care in the first three months. For pregnant teens ages 15-19 years, one in seven black mothers and one in ten white mothers receive little or no prenatal care. Inadequate care places the babies of young women at increased risk of low birthweight, infant mortality, and a host of other health complications.

From a study in 1985 on Project Good Health by the Department of Public Welfare, quoting the Department of Public Health in Massachusetts, "Pregnant teens are four and one-half times as likely not to have prenatal care as are older women, and, as a result, are more than one and one-half times as likely to have low birthweight babies."[182]

According to the Children's Defense Fund, "one-half of all deliveries involve some type of complications, and 20% of women who become pregnant have at least one serious health problem. Very young mothers who face the greatest health risks are the least likely to receive prenatal care early in pregnancy."[183] The National Center for Health Statistics reports that data indicates that the proportion of minority women and teenagers who received prenatal care remained at lower than average levels during the 1970's, and in the early 1980's, there was a decline in the proportion of 15-19 year olds who received first trimester care.

The report from the National Research Council, Risking the Future, states, "women from low income backgrounds and those who are young nonwhite and unmarried, and who have completed less than 12 years of schooling are at substantially greater risk of inadequate care."[184]

Many low birthweight births could be prevented and infant mortality rates reduced if teenage mothers received the proper prenatal care. A report from the Massachusetts Statewide Task Force on Preventing Low Birthweight and Infant Mortality states, "babies born to women who had no prenatal care are ten times more likely to die within a month of birth and five times more likely to be seriously underweight than infants born with adequate care."[185]

There are many studies that correlate high risk of birth complications to teenagers, and the inadequacy of, or lack of, prenatal care, with poverty and the affordability and availability of adequate health care for them and their children. Those who are especially at high-risk are black teenagers, the poor, and very young teens who become pregnant and give birth. The barriers to receiving adequate

prenatal care most often cited are: low income, poverty, unemployment, and underemployment, lack of insurance for maternal care, lack of transportation, and other factors that are linguistic, cultural, and attitudinal in nature. A crucial factor is that comprehensive prenatal care is not equitably available in all parts of the state.[186] According to an Issue Brief from the Children's Policy Information Project, "one argument that is as important as that of costs is the question of equity...the issue is one of equal opportunity. All groups should receive services that are generally accepted as improving the health status of children."[187]

According to the report, Risking the Future, "a major determinant of whether a woman gets adequate care, or any care, is whether or not she has insurance, or how much money she has. The problem of uninsuredness increased significantly in the early 1980's."[188] The report points out that personal poverty and unemployment mean that fewer families have access to employer-based insurance coverage.

The Children's Policy Information Project's report, "Infant Deaths as a Social Indicator", states, "with regard to prenatal care, the most prominent course for reducing infant mortality is to reduce unmarried childbearing, and enroll pregnant women in early and continuous prenatal care that is appropriate to their risks."[189] Target subpopulations should include minorities, the poor, and teenagers, who are at greater risk. Also, "further attention needs to be focused on the full scope of social supports and benefits that are provided to pregnant women and their infants. The practice in the United States is to provide less support than in other parts of the industrialized world."[190]

While teenage pregnancies are a very serious problem, "the problem may not start out as a health problem. It is an educational and socioeconomic problem. Teen pregnancies are supported by the health system rather than by other relevant systems. Health dollars alone cannot solve what is a very complex problem. Education may be as critical to the mother's success as better access to care."[191]

Studies consistently point to similar reasons why teenagers do not receive adequate prenatal care. These factors must be considered in any planning for program strategies.[192]

* Teens are often ignorant about the need for care and where to obtain it.
* Teens have a lack of understanding about health matters.
* Teens may be embarrassed.
* Teens may be fearful or parents, peers, and others' reactions.
* Teens may need their parents' consent to medical care.
* Poverty and the consequences of poverty.
* Teens may experience further difficulty in seeking care when there is a shortage of affordable care.

There have been a variety of programs initiated to help high risk adolescents obtain adequate prenatal care. Many are provided through public health departments, university hospitals, freestanding clinics, school-based clinics, youth-servicing agencies, and private physicians. Some programs provide prenatal care as a special service; others serve pregnant adolescents in the context of more comprehensive programs.

According to the Children's Policy Information Project report, "Infant Deaths as a Social Indicator", "when recommendations are made for improving participation of pregnant women in prenatal care the presumption is strong that the care will include:[193]

review of medical history and physical finding with appropriate treatment as indicated
genetic screening and counseling
routine laboratory surveillance
risk assessment
counseling concerning the hazards of cigarette smoking, drug use, and alcohol consumption
nutritional advisement and supplementation as appropriate
education and arrangements for delivery
assistance and support in preparation for breast-feeding and parenting
enrollment in appropriate entitlement programs such as Medicaid and Aid for Families with Dependent Children
Family planning counseling

In the article, "Preventive Health Care for Children", the authors point out that "one of the important variables concerning prenatal care which has essentially been left out of studies is the question of the content of that care."[194] Other factors that need to be included in the provision of programs and services to teens are:[195]

* It is crucial to identify what services are actually being provided under the term prenatal care, and to whom.

* Low income women may require more complex care due to health, economic, and social problems that make pregnancies and delivery more difficult.

* There is a need to focus on what kinds of prenatal care each population needs rather than on whether prenatal care is effective or ineffective.

* Along with the appropriate content of care, there must be the right kinds of providers delivering care.

* Where services are provided is also important. Schools are positive locations, and important ones, and may even be providers of low cost services.

* From a public policy point of view, the content of care and the manner of providing that care are particularly important. There are clearly different needs among racial, economic, and age groups that affect the manner in which care should be provided.

A further discussion of prenatal care among teenagers in Massachusetts is contained in the section on the Department of Public Health's MAPPS study.

Low Birthweight Infants

Low birthweight births are a major cause of infant mortality and childhood diseases, birth injuries, and neurological disorders, including mental retardation. Low birthweight infants are 20 times more likely to die than babies born at normal weight. Three-fourths of all infant deaths in the first 28 days of life, and 50% of all infant deaths in the first year, are the result in whole or in part, of low birthweight.[196] One in four low birthweight babies will be left permanently disabled.[197] One in four low birthweight babies who survive their first year is at-risk of a lifetime of disability. Low birthweight places infants significantly at-risk for mental retardation, cerebral palsy, epilepsy, developmental delays, learning disabilities, vision and hearing defects. Two-thirds of all low birthweight infants will require neonatal intensive care services, and 9% will need to be re-hospitalized at least once before they are a year old.[198]

Although survival of low birthweight infants has improved dramatically, the proportion of babies with low birthweight has not changed appreciably in more than 25 years.[199]

According to the Children's Policy Information Project, "a case cannot be established that major differences in birthweight or infant mortality are attributable to biological differences among ethnic or racial subgroups. The problems are that there have been no evaluations to assess the relative contributions to improved infant survival that would help to formulate public policies. The record is imprecise."[200]

Low birthweight and infant mortality rates are highest among the poor, teens, blacks, Hispanics, and poor whites. Infants born to poor women are one and one-half times more likely to die than those born to higher income women. For black infants the rate of death is twice that of white infants.[201]

Dr. Paul Wise, pediatrician and Director of Perinatal Epidemiology of the Joint Program of Neonatology at Harvard Medical School, has stated, "the survival of normal weight babies both during and beyond the first month, of low birthweight babies after they leave the hospital, and the rate at which low birthweight babies are born in the first place, are all deeply affected by alterations in socio-economic status."

Infants born to teenagers are in triple jeopardy, since unintended births to young unmarried women carry risks in each area. Also, inadequate access to basic needs services, such as housing, health care, nutrition, and education, often leads to poor health outcomes for babies born to teens. School-age mothers are one and one-half to two and one-half times more likely to have low birthweight babies as are older mothers. Over 11% of all live teen births, or 6.8% of all babies, will weigh less than five and one-half pounds at birth.[202] Teen mothers under age 16 are at the greatest risk of any age group for having premature births.

In the United States, over 17% of all births to teens under age 15 years are low birthweight births.

Factors Associated with Low Birthweight Births

The manual on prenatal care published by the Children's Defense Fund lists factors associated with low birthweight in infants. "Nearly all of the factors associated with low birthweight either apply directly to, or are prevalent among teens. These factors reflect both heightened social and medical risks. Low birthweight babies are most often born to mothers who:"[203]

are less than 18 years old (or over 34)
have previously had a low birthweight baby
suffer from some type of chronic health condition
are poorly nourished
smoke or use drugs or alcohol during pregnancy
receive little or no prenatal care
are black
are unmarried
are poor, or
have a low level of education

Massachusetts: Low Birthweight Births

According to several Massachusetts reports, there has been relatively little decline in the past decade in the rate of low birthweight births, an outcome known to be affected by prenatal care.[204] In Massachusetts, low birthweight births account for two-thirds of the 700 infant deaths each year. Those who do survive and are low birthweight, are at-risk for medical and developmental disabilities.[205] Of the approximately 4600 annual low birthweight babies born in Massachusetts, about 340 are disabled seriously, requiring long-term and specialized care services.[206] In 1983, the low birthweight rate for blacks was more than twice the rate for whites, 12.3 per 100 for blacks, and 5.4 for whites.

In 1984, teen mothers gave birth to 627 low birthweight babies, representing 13.6% of all low birthweight births, and 8.9% of all teen births. In 1983, teens had 589 low birthweight births. In 1985, teens gave birth to 593 low birthweight babies, 12.3% of all low birthweight births, and a slight decline to 8.5% of all teen births.

From 1981 to 1985, young teen mothers gave birth to nearly 3,000 low birthweight babies.

The chart on the following page gives the number of low birthweight births, by age, for 1984 and 1985, and the percent of low birthweight births to total births for each age group.[207]

Age	#LBW Births 1984	#LBW Births 1985	%LBW to Total Births 1984	%LBW to Total Births 1985
less than 15	16	10	19.0%	8.8%
15	31	37	11.6%	12.5%
16	90	90	12.6%	12.9%
17	122	103	9.0%	8.0%
18	174	154	8.4%	7.7%
19	194	199	7.5%	7.7%

Source and Derived Data Source: Dept. of Public Health, Division of Health Statistics and Research.

In 1985, the breakdown of maternal age and the number of low birthweight births to each age group, by race, is presented in the following chart. The Department of Public Health cautions against absolute interpretation of the statistics because the number of Hispanics and blacks are very small as compared with whites. Also, Hispanics are often combined with whites, and the numbers on birth certificates are not always accurate and reliable.

Age	All Races	Hispanics	Whites	Blacks
less than 15	10	1	3	5
15	37	6	18	9
16	90	20	45	23
17	103	20	50	29
18	154	17	94	33
19	199	23	137	28

Source: Dept. of Public Health, Division of Health Statistics and Research.

A report from the Department in 1985 states, "the areas of the state with the highest low birthweight rates generally rank high on other problem indicators as well, such as unemployment rates."[208] According to the Department, the cities with the largest 5 year rates, from 1979 to 1983, are as follows:

Boston	8.6
Holyoke	8.3
Springfield	8.2
Worcester	7.3
Brockton	6.9
Malden	6.9

New Bedford, Taunton, Lawrence, Lynn, Fall River, Pittsfield, Cambridge, Chicopee, Haverhill, Lowell also had rates in excess of the Massachusetts low birthweight rate of 6.0 births. These cities and towns also correspond to areas of the state with high numbers of teen births.

According to the Department of Public Health, there were higher rates of low birthweight in infant mortality for blacks and Hispanics in Springfield, Boston, and Holyoke. Much of the statewide variations in low birthweight rates are the result of social and economic conditions.

In 1985, the 20 Massachusetts communities with the highest numbers of low birthweight births born to teens 19 years and under were:

City/Town	1985	1984
Boston	128	157
Brockton	14	24
Cambridge	12	4
Chelsea	9	4
Fall River	23	16
Fitchburg	6	8
Framingham	6	1
Haverhill	7	5
Holyoke	18	16
Lawrence	14	26
Lowell	30	19
Lynn	10	13
New Bedford	19	20
Pittsfield	11	8
Plymouth	5	1
Somerville	11	5
Springfield	44	46
Taunton	6	7
Weymouth	6	4
Worcester	30	32

The following cities and towns were among the highest for 1984, but not in 1985: Attleboro, Chicopee, Quincy, Waltham.

Infant Mortality

According to the Children's Defense Fund, "the United States has slipped to last place among twenty industrialized nations in the reduction of overall infant death rates. Nearly 40,000 of the 3.7 million babies born in 1984, died before their first birthday, a rate of 10.8 infant deaths per 1,000 live births."[209] While deaths among infants and children has decreased, the first year of life still has the highest death rates until age 65 and over.[210] The Children's Policy Information Project states that the post-neonatal infant mortality rate, or deaths from 28 days to 11 months, is heavily influenced by environmental circumstances that contribute to accidental deaths and contagion. Infant mortality rates (IMR) are highest among populations with lowered socioeconomic conditions, poor sanitation, unsafe housing, limited water supply, and low maternal education.[211] One special indicator that correlates worldwide with infant mortality is the illiteracy rate.

In January, 1986, Marian Wright Edelman stated, "we are concerned about increasing mortality among older infants, because deaths among babies between 28 days and one year are more likely to be caused by environmental factors such as poverty, poor nutrition, inadequate housing and sanitary conditions, and a lack of basic health care."[212]

The Children's Policy Information Project Issue Brief, "Infant Deaths as a Social Indicator", states, "infant survival rates are the lowest among young mothers, the black population, families of low socioeconomic status, and low educational attainment, and unmarried mothers. The U.S. has followed the most

expensive policy possible for reducing infant mortality rates. This has consisted of intensive medical care for low birthweight babies. The prospects are not great for further substantial reductions in infant mortality without taking steps to reduce the proportion of infants who are born too small or too soon."[213]

The report also states that the correlation between poverty and high infant mortality rates is undisputed. Edelman recommends that the situation can only be improved with systematic funding increases for key preventive maternal and child health and nutrition programs.

In 1980 the Surgeon General set a goal in the United States to reduce infant mortality rates to 9 deaths per 1,000, and to reduce the rate of racial and ethnic subgroups to 12 deaths per 1,000 by 1990. In order to reach these goals, states will have to service high-risk women through medical and nutritional care, and parenting education.

The Children's Defense Fund states that black infants continue to die at nearly twice the rate of white infants. Washington, D.C. was among the 10 highest in infant mortality rates, and the worst for providing women with late or no prenatal care. The Children's Policy Information Project reports that the infant mortality rate of babies born to Indian parents on reservations, up to the 7th day, is about the same or actually slightly lower than the national infant mortality rate. But, post-neonatal mortality rates for babies up to one year is significantly higher. Indian infants often get inappropriate medical care after leaving the hospital. Also, when infants leave the hospital, they often are going back into environments that are not conducive to good health or survival.[214]

Two-third of infant deaths are associated with low birthweight. As teens, especially young teens, are more likely to have low birthweight babies, infant mortality rates are high among teen births.[215] According to the Children's Defense Fund, infant mortality rates among young teens are higher than overall rates. Data for 1984 states that the infant mortality rate for teens under 15 years was 35.7, and for teens 15-19 years, was 13.3, a 17.7 increase over 1983.

An article by Arline T. Geronimus, titled, "The Effects of Race, Residence, and Prenatal Care on the Relationship of Maternal Age to Neonatal Mortality"[216] in summarizing studies states, "the infants of teenage mothers in the United States are most likely to be born among socioeconomically disadvantaged populations where women at any age may be victims of environmentally induced risk factors for poor childbearing prognoses. Factors include nutritional inadequacy, excessive stress, life-long medical underservice, inadequate housing and sanitation, and many medical conditions and diseases, both chronic and acute." Geronimus states that studies provide important evidence that environmental risk factors can play a key role in the association between teen maternity and poor pregnancy outcome. This study concluded that blacks experience higher rates of neonatal mortality than whites at any age. The ages at highest risk of neonatal mortality are also more likely to have the greatest percentage of blacks, rural residents, and women receiving inadequate prenatal care, which may be the result of the physiological consequences of their environmental disadvantage. "The effect of race on birthweight is so much greater than that of prenatal care that, in this study, blacks in the preferred prenatal care group remain at increased risk, exhibiting twice the relational risk of

bearing very low birthweight infants as whites with inadequate prenatal care. Results indicate that neonatal risks associated with teen maternity are not uniform, they vary by teen age, prenatal care, and racial identification."[217] The study also points out that higher black neonatal mortality rate among blacks is not attributable to the larger numbers of births among black teens.

Massachusetts: Infant Mortality

Children born to women who have had no prenatal care have a neonatal mortality rate (infant deaths in the first 28 days of life per 1,000 live births) 10 times greater, and a low birthweight rate (births under 5.5 pounds per 100 live births) 5 times greater than for women who receive adequate prenatal care

In 1983, the Massachusetts infant mortality rate of 9.0 per 1,000 live births was lower than the provisional, national rate of 10.9 per 1,000.[218] The infant mortality rates in Massachusetts for 1981-1984 were as follows:[219]

1981	9.6 per 1,000 live births
1982	10.0
1983	9.0
1984	8.9

Stating that infant mortality is one of the most sensitive indicators of a society's overall health, the Mass. Department of Public Health found in 1984 that the 1982 infant mortality rate had increased for the first time in 9 years. In 1985, the infant mortality rate worsened in 13 cities and towns in the state. The newborn death rate increased by 10%, and infant deaths increased from 8.9 per 1,000 in 1984 to 9.1 per 1,000 in 1985.[220] The increase also reflected a further decline in the use of early and continuous prenatal care among pregnant women. In Boston, 15.5 infants per 1,000 died, an increase from 11.7 in 1984. The Department of Public Health cautions that possibly stillbirth numbers have been included in infant death rates.

In May, 1985, a report from the Department of Public Health stated, "infant deaths and disability occur across the state in every racial, ethnic, and age group, but gaps between groups can be identified. While the rates of low birthweight and infant mortality have been declining among all racial and ethnic groups, the gap between rates for black and white infants has been roughly doubled during most of the decade, and appears to be widening. The rates for Hispanic infants appear to fall between the rates for the other two groups. Rates for communities such as Springfield, Holyoke, and Boston exceed the state rate, and are more than double the rates for other communities in the state."[221]

In February, 1987, the then-Commissioner of Public Health, Bailus Walker stated, "the increase in the 1985 infant mortality rate reflects increases among high risk groups and communities, and reflects decline in early and continuous use of prenatal care."

The increased rates in 1985 occurred in the following cities and towns:

Cambridge
Lowell
Lynn
New Bedford
Pittsfield
Framingham
Taunton
Plymouth
Fall River
Somerville
Newton

Small numbers that may not be a trend occurred in Framingham, Somerville, and Newton. The following chart appeared in the Boston Globe in January, 1987, based on information from data from the Department of Public Health.

Infant Mortality Statistics for Some Massachusetts Cities and Towns

	1984		1985		%Adequate Prenatal Care		%Obstetricians in Medicaid as of 9/86
	Number	Rate	Number	Rate	1984	1985	
Boston	100	11.7	138	15.4	78.8%	71.8%	n/a
Brockton	34	13.0	32	12.1	68.8	67.9	73%
Cambridge	10	9.3	17	15.0	83.0	81.9	66%
Fitchburg	4	6.8	7	10.6	69.9	67.2	33%
Holyoke	10	13.4	10	12.4	51.4	52.2	50%
Lawrence	21	16.1	15	9.9	70.9	63.5	57%
Lowell	20	11.6	26	14.8	68.7	63.2	66%
Lynn	11	8.4	20	14.6	71.8	73.2	44%
Plymouth	3	5.2	6	8.9	78.1	75.7	42%
New Bedford	12	8.1	17	11.5	65.2	69.6	87%
Springfield	34	13.0	32	12.1	68.8	67.9	73%
STATEWIDE	699	8.9	745	9.1	79.7	78.6	66%

The Children's Defense Fund reported that Boston was among six of the 22 major American cities that posted an increase in infant mortality rates between 1983 and 1984. "In Boston, where 8,000 babies are born annually, about 4900 expectant women live in neighborhoods where infant mortality rates are especially high. About 3,000 were screened for factors that put them at-risk of delivering prematurely, or bearing a low birthweight infant."222

Out of concern for the increases, and for persistently higher rates among poor minority and teen women, in 1984, the Department of Public Health convened a Task Force. The FY86 budget included nearly $8 million to implement the Task Force recommendations: money for WIC expansion; support for community coalitions to develop local strategies; funds for media and educational materials; funds to support the development of up-to-date standards for maternity care; expansion of comprehensive community prenatal programs; implementation of programs to pay for maternity care for low-income uninsured women, called Healthy Start, discussed in this section. Each initiative was continued for 1987.

The following is a listing of the recommendations for strategies to reduce infant mortality and low birthweight births from the Task Force of the Department of Public Health, "Closing the Gaps".

1. Strategies must be specifically targeted to, and tailored for high risk groups and areas of the state.

2. Maternity and infant health care must be affordable for all.

3. Comprehensive maternity and infant care services must be readily accessible to all women in the state.

4. Every woman of childbearing age should be well-informed about factors contributing to healthy babies and about availability of services.

5. Ongoing monitoring of maternal and infant health status and needs must be strengthened.

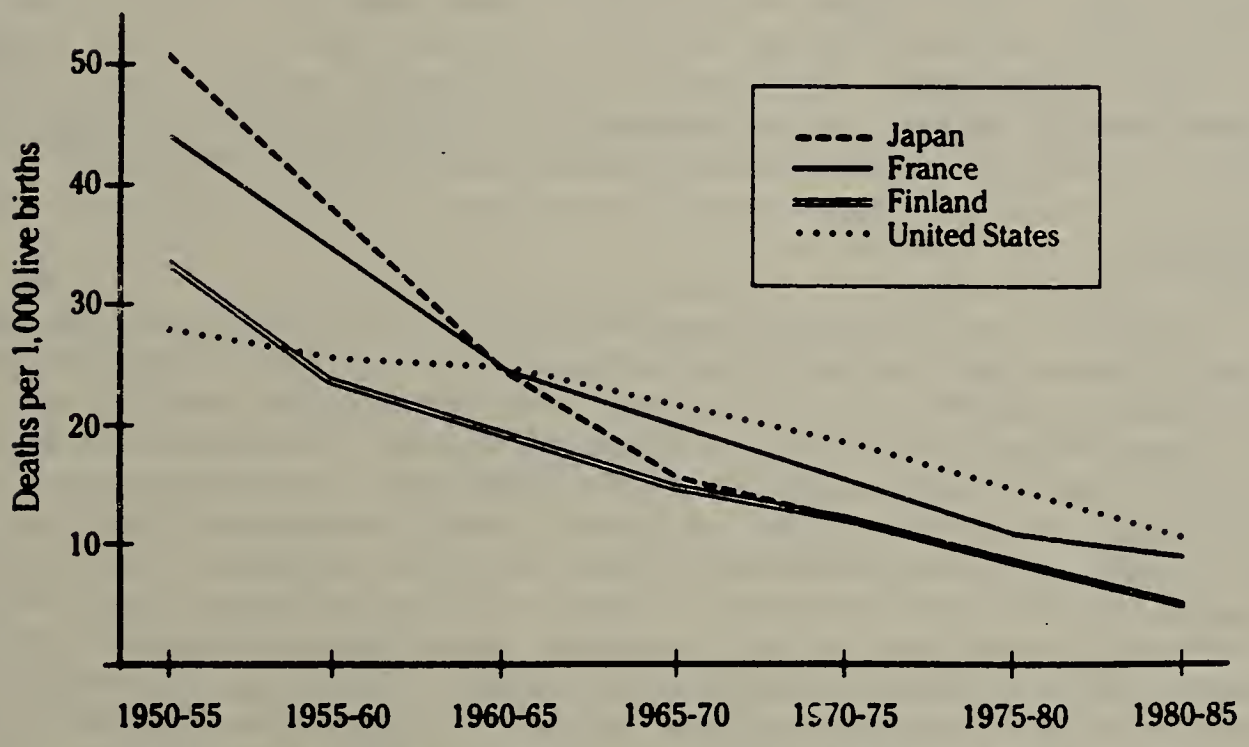
6. Gaps must be identified, by race and ethnicity, by geographic area, by income level, and by age.

Recent preliminary reports in Boston indicate that the infant mortality rate for 1986 has declined, from 138 in 1985 to 120 in 1986.

All studies consistently state that there are many complex factors behind infant mortality, neonatal mortality and morbidity, such as poverty, stress, lack of, or inadequacy of, prenatal care and health care, sufficient food and medical care, family structure, and family life, and other personal, social, economic, and environmental factors that influence the health of the mother and the birth outcome of the baby.

The charts on the following page, from the Children's Defense Fund, give Infant Mortality Rates for Selected Countries, from 1950-1985, and for 1985 only.

INFANT MORTALITY RATES, SELECTED COUNTRIES, 1950-1985



Source: Children's Defense Fund, *The Health of America's Children: Maternal and Child Health Data Book*, 1987.

INFANT MORTALITY RATES, SELECTED COUNTRIES, 1985

Rank	Country	Rate*	Rank	Country	Rate*
1	Finland	6	14	Spain	10
1	Japan	6	14	United Kingdom	10
1	Sweden	6		*U.S. (White)*	10
4	France	8	19	Austria	11
4	Denmark	8	19	Italy	11
4	Netherlands	8	19	United States (Total)	11
4	Norway	8	22	New Zealand	12
4	Switzerland	8	23	Israel	13
9	Australia	9	24	Greece	14
9	Belgium	9	25	Cuba	15
9	Canada	9	25	Czechoslovakia	15
9	Hong Kong	9	27	Bulgaria	16
9	Singapore	9	28	Costa Rica	19
14	German Democratic Republic	10	28	Poland	19
14	Germany, Federal Republic	10	28	Portugal	19
14	Ireland	10		*U.S. (Black)*	19

Source: UNICEF.

Source: "A Call for Action to Make Our Nation Safe for Children: A Briefing Book on the Status of American Children in 1988", Children's Defense Fund, Wash., D.C., 1988.

Special Supplemental Food Program for Women, Infants, and Children - WIC

The WIC program was enacted by Congress in 1972, and is supported by the U.S. Department of Agriculture. The program provides nutritional food supplements and nutrition education to low and moderate income pregnant, post-partum, and nursing women, and infants and children under age five who are certified as nutritionally at-risk. WIC is operated by local health clinics and other authorized health facilities. WIC benefits are provided by over 7,000 clinics throughout the country. About 500,000 women of all ages receive WIC services annually involving about 15% of the total births in the United States.[223]

Eligibility

Eligibility requirements are targeted to women and children whose family income is less than 185% of the federal poverty level. States can establish different income standards as long as they are between 185% and 100% of the poverty level, and the clients have a documented health or nutrition deficiency, or are at-risk of developing such a problem.[224] To qualify, mothers and children must be individually certified as "nutrition risks" because of dietary need and inadequate income. Each participating mother or child receives individually prescribed packages of food high in protein, iron, calcium, vitamin A and vitamin C.

The WIC foods include milk, cheese, eggs, 100% fruit juices, iron-fortified cereals, peanut butter, dried peas and beans, infant formula and infant cereal. A participant in the program receives 4-5 vouchers a month. Each voucher lists the specified foods prescribed and the amount provided for a month. Once a participant has been certified and had the WIC food package prescribed, she will receive vouchers each month at the WIC office. The monthly visits offer WIC another opportunity for informal counseling.[225]

Infants and children are re-evaluated each six months to determine if they are still WIC-eligible. Pregnant women remain eligible until six months post-partum if they are bottlefeeding, and up to one year if they are breastfeeding. The WIC program in Massachusetts is administered by the Department of Public Health, and integrates its services with other programs to maximize its effectiveness.

Administration and Operation of WIC

The U.S. Department of Agriculture (USDA) administers WIC at the federal level. State health departments are the state agencies involved with WIC. Locally, city or county public health departments, private non-profit health clinics, hospitals, and non-profit organizations serving health and welfare needs are responsible for WIC. USDA allocates funds to states based on a funding formula and state health departments allocate funds to local agencies.[226]

Program participants receive vouchers for regulatorily-defined food packages which are redeemable through local vendors who have a formal agreement with departments of public health in each state.

WIC clinics may provide supplemental foods in one of three ways: obtaining foods from local firms and distributing them directly; arranging for home delivery; giving mothers vouchers to exchange for specific items at authorized grocery stores. Most clinics give participants vouchers. Participants also learn about the particular nutrient needs of pregnancy, lactation, infants, young children, food sources,

and ways to shop and prepare economically well-balanced meals.

WIC operates in all fifty states, Puerto Rico, the Virgin Islands and Guam. In addition, 34 reservations and tribal councils contract directly with USDA to provide WIC services. WIC programs operate in all but about 200 of the nation's 3,100 counties. However, due to limited funding in most counties, only some of the women, infants, and children in need of WIC receive program benefits.

Funding

The annual WIC appropriation provides money for food and administration. The WIC law stipulates that 80% of the funds are to be used for food and 20% for administration. Administrative funds cover program administration, including staff salaries, certification which includes nutrition screening, nutrition education, and a whole range of related costs such as outreach, printing of food vouchers, development and accountability of food delivery systems and program monitoring.[227]

According to information from the Coalition to Improve WIC, which includes Mass. Law Reform Institute, Mass. Advocacy Center, Project Bread Hunger Hotline, Alliance for Young Families, and others, in FY84, the Commonwealth became the first state in the country to supplement federal WIC funds. Governor Dukakis proposed and the Legislature passed, a $6.6 million child nutrition package which included $2.3 million in supplemental WIC funding for FY84 and about $2.1 million for FY85. For FY86, the Department of Public Health estimated that Massachusetts federal WIC allocations would be sufficient to maintain the expanded caseload. The Legislature appropriated another $1 million to meet additional needs. $3.25 million in expansion funding was secured in FY87 and FY88, to allow the WIC caseload to expand from a total of 63,000 to 69,800 by June, 1988. The advocacy recommendation for WIC for FY89 is an additional $2.75 million in state funding to be added to the program in order to reach 80,000 people by June, 1989, with $1 million to restore the inclusion of cheese in the food package.

Cooperation with Other Programs

The WIC law and regulations require that WIC be coordinated with other programs serving high-risk women, infants, and children. family planning and prenatal services are two programs specifically mentioned in the regulations. Many comprehensive care programs for pregnant and parenting teens include nutrition education and services as components of their servicing package. Others have linked their program participants to local WIC services.

School-Based Clinics and WIC

There are three ways school-based clinics can get involved with WIC.[228] They can be local WIC sponsors; they can subcontract with local WIC agencies; or they can refer teens to WIC clinics. The second and third alternatives are the most practical for SBC's. As a subcontractor, SBC staff would: 1. certify teens for participation, 2. provide vouchers, 3. provide nutrition education, and, 4. carry out administrative work for minimal reimbursement.

Research and Cost Effectiveness

Research studies indicate that early and consistent participation in WIC

and other health and nutrition-related programs helps first pregnancies, and also subsequent pregnancies, before and after birth, and during pregnancy. Nutrition-related factors affect pregnancy outcomes, especially those involving low birthweight babies. Those who are at high-risk of nutritional deprivation during pregnancy are teens, women who are poor, unmarried, and under-educated. Research on nutritional deprivation concludes that nutritional assessment and services should be a major component of prenatal care, especially for women in high-risk groups.[229]

Studies have shown that once high-risk women, including teenagers, enter WIC programs, more than 90% participate until the birth of the infant.[230] Evaluation studies on WIC programs indicate that prenatal participation in WIC is associated with improved pregnancy outcomes, especially low birthweight status among infants. While the evidence is difficult to absolutely confirm, there is proof of definite increases in the mean birthweights of babies, and decreases in the percentage of low birthweight babies.[231] Also, "from its inception, the WIC Program has proven incredibly effective at preventing and reducing infant mortality, low birthweight births, and failure to thrive in children."[232]

A recent evaluation of the WIC Program in Massachusetts determined that participation in the WIC program generally improves the outcome of a woman's pregnancy: the infant is less likely to be premature or to be born with a low birthweight; the longer a woman participates in WIC during her pregnancy, the more likely she is to benefit from the program.[233]

Studies have also proven the cost-effectiveness of WIC program participation. The cost of WIC participation per person per year is approximately $500, as opposed to short and long-term costly consequences of health care problems for mother and child without nutrition care, nutrition education, and other types of services. More information on health care needs and services is contained in sections on prenatal care, low birthweight infants, and infant mortality rates.

A recent Missouri study found that for every dollar expended on WIC, $1.42 is saved in reduced medical costs during the baby's first 30 days of life alone.[234]

Massachusetts WIC Programs

Despite increased and expanded funding for WIC programs, it is estimated that only about 45-50% of all eligible women, infants, and children in the state actually receive WIC services.[235]

The following is a list of WIC Programs in Massachusetts. For further information, people can call 1-800-WIC-1007.

Boston Area

Allston-Brighton	782-7000 x2439	Chelsea/Charlestown	242-5740
Cambridge	498-1091	Harvard Street	825-3400
	Jamaica Plain 522-4700		
Quincy	770-4242	Somerville	666-4400 x140
Roxbury/ Mattapan	427-1000	South End	266-7492
	Upham's Corner 225-3994		

Programs in the state that focus on pregnant and parenting teenagers, and contain a WIC component, are indicated as such in the listings of programs and services in Massachusetts by Health Service Area.

For the Legislative session 1988, H3634 "An Act to Improve Maternal and Child Health" has been filed by several members of the House and Senate, working with Mass. Law Reform Institute, and Project Bread/Hunger Hotline. The bill is designed to expand the WIC program by:

formally enacting the WIC program as part of Mass. law
requiring that all WIC participants who are in need receiving the full amount of food benefits authorized by federal law
setting a goal that by FY91, all women, infants, and children who are financially and medically eligible will be entitled to receive WIC program benefits
correcting certain administrative problems which currently exist for WIC program applicants and participants

The bill would require that sufficient additional state funding in the amount of $2.75 million be made available in FY89 to allow the WIC program to reach 80,000 people.

The Title V Maternal and Child Health (MCH) Block Grant Program

Title V was originally enacted in 1935 as part of the New Deal. It was then restructured in 1981 by Congress. The Block Grant provides states with modest amounts of funding to plan, develop, deliver, and administer public health programs for mothers and children.[236] "Services provided with MCH Block Grant funds range from 'well baby' and immunization clinics to sophisticated treatment and rehabilitation care for handicapped infants and children."[237]

For fiscal year 1985, states received $478 million to administer the MCH Block Grant. Nearly all states supplement the program beyond the basic state matching requirements, often for medical and hospital treatment for handicapped children. Many states now provide additional funds for MCH services targeted at high-risk pregnant women, especially for cost-effective prenatal care programs.

Funding

Funds for prenatal and newborn care are allocated by state MCH agencies, usually located in state public health departments. The federal law does not set any minimum requirement for services that must be provided. A wide variety of services ranging from simple tests and referral services to complete prenatal care, are provided from state to state and county to county. The Block Grant also does not set limits on the types of care to be provided, but does prohibit the use of funds for certain types of hospital care. "Thus, MCH Block Grant funds could be used to underwrite local activities for which there is no Medicaid reimbursement such as counseling, health education, and case-management services."[238]

A report by the Children's Defense Fund, "A Manual on Providing Effective Prenatal Care Programs for Teens",[239] states that the Block Grant is usually so small that it may be termed a "gap filler". According to the report, "adolescent pregnancy advocates should use the program's annual needs assessment and planning process as an opportunity to bring to state and local public officials' and medical care providers' attention the need for Block Grants to be invested in new

services or as "seed money" to start up comprehensive services programs in locations." The report points out that any public health service funded in whole or in part by MCH funds must be furnished free of charge to women and children who live below the federal poverty level. "Not only are public clinics bound by this "free care" requirement, but so are any providers serving patients under contract with the state MCH agency. Any charges imposed on persons living above the poverty level must be adjusted for family size and income."[240]

Programs Funded Through MCH Block Grant Funds

Most states use some of their MCH Block Grant funds to administer special comprehensive maternity and pediatric clinics known as Maternity and Infant Care (MIC) projects and Children and Youth Projects. Massachusetts is one of the states that has MIC projects, discussed in the following section. These clinics usually offer comprehensive services, including outpatient and inpatient medical care, counseling, outreach, and other services to pregnant women, children, and teens. "At least one state, Kansas, devotes all its MIC funds to serving teens, and in St. Paul, Minnesota, one of the nation's most successful and enduring school-based health clinics for teens is in reality a MIC project."[241]

Improved Pregnancy Outcome (IPO) and Improved Child Health Outcome (ICH) projects may also be funded by some states with MCH Block Grant monies. These projects involve special maternity and pediatric care programs. Initiated as demonstration projects with special federal grants in 1978, "these projects have been successful at stimulating and developing more services to low-income women, infants, and children." The Children's Defense Fund report encourages advocates and other interested persons to identify these projects, since they can be valuable resources, and sources of care and supportive services for low-income teens and their babies.

Many states have strengthened their commitment to prenatal care services and programs. CDF's report notes that Ohio, South Carolina, Michigan, and New York have all expanded their financial contributions to publicly-funded maternity care. Advocates have identified a need for such services in all communities within a state, either through public clinics whose staff provides direct care, or referral programs in which uninsured women are referred to private providers in the community. Many states have already developed such care programs in each county within the state.

The CDF report states that advocates should also focus efforts on the content and quality of prenatal care provided by Title V-funded clinics. Several studies have stressed that care furnished to low-income and high-risk women must be of especially high quality. "Public prenatal care programs should be making efforts to include in their protocols many of the relatively low-cost but highly effective components of a good prenatal care program including:"[242]

risk assessment
health education
nutrition counseling
provision of additional visits
instruction in stress management

Excerpted from "A Manual on Providing Effective Prenatal Care Programs for Teens", Children's Defense Fund

The Children's Defense Fund has stated that among the major federal cutbacks is included an 18% cut in MCH funding.

Programs and services in Massachusetts containing MCH components are designated as such in the directory of listings by Health Service Area.

Maternal and Infant Care Program in Massachusetts (MIC)

According to the Department of Public Health, Division of Family Health Services, "the primary goal of the Maternal and Infant Care program has been to provide comprehensive prenatal care to low-income women at-risk for poor perinatal outcomes. The goal is to ensure that pregnant women have access to quality comprehensive prenatal care."[243] The target populations include women 19 years of age and under, unmarried women, minorities, uninsured women and low-income women.

The Department of Public Health, DFHS, conducted a study of the MIC program over a five year period. The report of the study, "The Five Year Period of the Maternal and Infant Care Program in Massachusetts, 1980-1984", states that the objectives are attained by funding community health agencies and hospitals that target services to at-risk women residing in their service areas. "The MIC program has grown from 11 sites and 2020 MIC-affiliated births in 1980, to 21 sites and 3984 births in 1984."[244] Data collected for the study on all MIC users was designed to obtain demographic, behavioral, obstetric, and perinatal outcome information. The report and information from the study are intended to serve the following purposes:[245]

Describe the sociodemographic characteristics of the MIC population.
Explore whether the target populations are being reached.
Examine the factors influencing utilization of perinatal care services.
Examine the associations between certain sociodemographic and medical variables, and selected birth outcomes.
Explore changes over the five year period in terms of population characteristics, utilization of services and birth outcomes.

The major findings of the five year study are summarized as follows:

1. Description of the MIC population: Adolescents, ages 13-19, account for 27% of all MIC deliveries, while only 10% of Mass. deliveries were to women in this age group. The number of teens has increased each year. In 1980, 6% of pregnant teens received their prenatal care at a MIC site; in 1984 this increased to 14.5%. About 37% of the births to teens in the MIC designated service areas received their care at MIC sites. Sixty percent of MIC deliveries were to unmarried women compared to 16% in the state.
   Thirty percent of babies born to mothers of Hispanic origin in Mass. were MIC participants; for Asian women the figure was 42%; for Blacks the figure was 13%.

2. Utilization of Prenatal Care Services: A disturbing trend emerged in this area. The precentage of teenagers having adequate utilization (as defined by when care began, how many visits occurred, and adjusted

2. for gestational age) declined from 37% to 30% from 1980 to 1984. Similar declines were noted for registration in the first trimester for both MIC and state teens. The MIC program needs to strengthen the outreach system to bring teenage women into care sooner.

3. Analysis of Perinatal Outcome Measures: Adequate prenatal care makes an important difference, even among high-risk populations. Women who had adequate utilization had significantly fewer low birthweight babies compared to women who utilized fewer prenatal services. Women who had inadequate utilization were 37% more likely to deliver a LBW baby compared to women with adequate utilization.

Women who smoked had a greater risk of delivering a low birthweight baby, being transferred to a neonatal intensive care unit, and having a premature baby.

The report describes the MIC population specifically targeted: adolescents, unmarried women, minorities, uninsured women and low-income women. Research has shown that these groups are more likely to have inadequate prenatal care utilization and be at greater risk for poor perinatal outcomes. The report points out that these categorizations, of themselves, may not be the source of poor outcomes. Also, "race, per se, may not be the risk factor for adverse birth outcomes. It may be a marker for other factors such as lower income, poor housing conditions, or less than adequate nutrition."[246]

The following table gives the percent and number of teenagers with adequate utilization of care by race, from 1981 to 1984.

Percent and Number of Teenagers (Aged 13-19) with Adequate Utilization by Race, 1981-1984

	BLACKS		HISPANICS		WHITES	
year	percent	number	percent	number	percent	number
1981	32.3	39	42.6	55	47.0	61
1982	33.1	55	43.1	66	30.8	52
1983	28.4	58	35.7	82	38.2	97
1984	22.2	50	34.3	104	37.6	151

Recommendations and Conclusions from the Report:

* Efforts need to be directed at getting high-risk women into care early.

* Strategies must be developed that will reach minority adolescents, particularly young black women, because they had the lowest rates of adequate utilization.

* Programs that serve teens need to identify ways of getting them into care as early in their pregnancies as possible. Early and continuous care is essential.

* Community-based outreach to women, especially adolescents, may be most effective.

* Programs need to develop referral networks to services which encourage and advocate for job training, educational and vocational counseling and day care.

* The MIC program is truly serving the target population and has been most effective in increasing positive birth outcomes for a high-risk population over time.

The MIC report contains detailed charts, data, and other information on the findings and conclusions of the study.

MIC programs in Massachusetts are designated as such under the directory of listings by Health Service Area.

Community and Migrant Health Centers

According to the Children's Defense Fund, these centers are two of the nation's most important health care providers for disadvantaged persons. "In 1982, these centers, funded by the federal government, and located in rural and urban areas and along the migrant stream, served over five million persons, two-thirds of whom were women of childbearing age and children. These centers are a key source of health care for pregnant adolescents and their babies because of the high quality and comprehensive care they offer."[247]

Community Health Centers (CHCs) exist in areas of the country that have been designated as "medically underserved." One of the factors used in measuring whether an area or population is medically underserved is its infant mortality rate. Therefore CHCs tend to be located in areas with large numbers of high-risk pregnant women.

CHCs and Migrant Health Centers (MCHs) must offer services that include prenatal, delivery, postpartum, pediatric, and family planning services. Services must be provided at reduced fees to persons living below the federal poverty levels, and must be adjusted for family size and income. "Thus, in identifying sources of health care for pregnant teens, it is important to develop linkages to these programs."[248] All centers follow the same standards and guidelines for the content of the care they provide so that services are of uniformly high quality. Providers are encouraged to provide outreach services to identify and treat women early in their pregnancies. Collaborative efforts between local and state maternal and child health agencies and Community Health Centers should be established.

Medicaid

While the Medicaid program in Massachusetts is administered through the Department of Public Welfare, the program will be discussed in this section on health programs as it is a major source of funding for health services.

Medicaid was established in 1965 as Title XIX of the Social Security Act. It is a federal-state matching program that provides medical assistance to low income persons who are categorically needy. Within federal guidelines, each state designs it's own program, and programs vary from state to state. The federal grant-in-aid program provides an entitlement to medical care coverage for certain categories of low income families. The largest group of persons entitled to Medicaid is the AFDC population. About 45% of all Medicaid recipients are children. Without Medicaid, 8 out of 10 poor children would be completely uninsured.[249] According to the Children's Policy Information Project, "Medicaid will become more critical for health care as numbers of children in poverty increases."[250] Medicaid is the primary program used by states to promote the health of children living in low-income families. Approximately 10 million children and youth are currently served by Medicaid.

For persons who satisfy eligibility requirements for coverage for certain types of medical and remedial care, payment is made on the beneficiaries behalf to providers who agree to treat medical patients. "The program is frequently administered by a state agency whose major responsibility is to pay for the medical care that is provided rather than to design and promote public health programs."[251]

Medicaid is the major source of health care funding for low-income women of childbearing age, and children, who are the most dependent on Medicaid and for whom Medicaid represents the largest proportion of all health care funding.[252] According to the Children's Defense Fund, "Medicaid represents 55% of all public health funds spent on children; pays 30% of all hospital deliveries to adolescents; pays over 25% of all hospital discharges involving children under age six; pays 29% of all hospital discharges involving black patients; and 26% of all hospital discharges involving Hispanic patients. The largest single hospital inpatient service funded by Medicaid is routine newborn deliveries."[253] Medicaid pays for 30% of all hospital deliveries involving pregnant teenagers, at an annual cost of about $200 million a year.[254]

Services

All states are required to offer services to the categorically needy: inpatient and outpatient hospital services, laboratory and x-ray services, skilled nursing facility services for those over 21 years, and home health services for those requiring skilled nursing services, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for those under 21 years, family planning services and supplies, and physician services.[255]

According to the Children's Defense Fund, states must provide the following services to all categorically needy Medicaid beneficiaries:[256]

inpatient hospital care
services in skilled nursing facilities
outpatient hospital clinic services
physician and rural health clinic services
laboratory and x-ray

nurse midwife services
family planning services and supplies
Early and Periodic Screening Diagnosis and Treatment
Services for beneficiaries under age 21

One of the required services that all state Medicaid programs must furnish to beneficiaries under age 21 is EPSDT services. This program was enacted by Congress in 1967, and it's initial purpose was to finance widescale outreach efforts to identify, screen, and treat very poor children suffering from potentially handicapping conditions. In many areas of the country, the program has grown into a comprehensive program that pays for a broad range of preventive health services that children of all ages need. According to some advocates, there are problems with EPSDT services as to their effectiveness, the range of services provided, and as to the level of comprehensiveness in services provided. Also, according to advocates, there are problems with follow-up on care services provided. In Massachusetts, there are some good dental services provided.

According to the Children's Defense Fund, there are minimum services that are to be offered under EPSDT:257

* Provide an effective program for informing eligible families about services that are available.

* Furnish all children who request services with a special package of benefits that include a comprehensive health exam; treatment needed, and referral to providers.

* Furnish all services in a timely fashion, within six months of the request.

* Furnish a family with necessary scheduling assistance and transportation.

* Furnish all care in accordance with a periodicity schedule, which identifies all the ages at which screening and treatment should be provided.

There is some evidence that eligible adolescents covered under this program may receive a more generous package of services than those provided to Medicaid recipients.258 A further discussion on EPSDT services is in Section 3.

The Medicaid program offers a myriad of options to states. Massachusetts had adopted most of the federal options. The federal law is broad, and coverage can be provided for nearly any type of medical or remedial care recognized under a state law. Examples of these services are case-finding by public health nurses, pregnancy risk assessments, pregnancy planning, health education, nutrition counseling, and pregnancy case management.259 All these are potentially Medicaid reimbursable activities. With regard to children, the program permits states to provide targeted and additional benefits that are not offered to adult beneficiaries.260

Certain minimal services, such as physician services, are uniformly provided, but such services as health or nutritional counseling are a state option. "State programs have the flexibility to finance nearly any necessary maternal

and child health care services they choose for any poor pregnant women and children, through any combination of qualified providers they may select."[261] Of serious concern in most all states is that because of low levels of reimbursement, about one-half of physicians offering obstetrical services do not participate in Medicaid.

The types of health services that can be reimbursed under Medicaid, according to the Children's Defense Fund are:[262]

1. hospital care
2. physician and nurse midwife services, including as many pregnancy exams and follow-up care as is needed, and services for the baby
3. preventive, diagnostic, therapeutic, or rehabilitative services offered by physicians or any other type of licensed practitioner
4. services furnished by comprehensive care clinics, including school-based or free-standing clinics
5. prescribed drugs
6. outreach, health education, case-management, transportation services

In 1984, the Child Health Assurance Program was enacted and extended Medicaid coverage to all low income pregnant women and children, as categorically eligible. The program added 200,000 persons to Medicaid and required all states to provide coverage to all children living below income levels used to determine eligibility for AFDC, including two-parent families. The program also requires states to provide medical services to first-time pregnant women living in families below the eligibility income level. Many states are going beyond this, and are expanding the Medicaid eligibility laws for their states. According to the Children's Policy Information Project, "even with the CHAP program, medically-funded services will only be provided to about one-half of all children living in poverty in any given year."[263] However, CHAP did reduce some disparities in access to care for groups of mothers and children that previously were not covered under state Medicaid programs.

Eligibility

All AFDC recipients are automatically eligible for Medicaid. In 1985, with a major effort from the Children's Defense Fund, coverage of all categories of very poor pregnant women in the Medicaid program was achieved. Also, a timely eligibility determination process was established. The Deficit Reduction Act, enacted by Congress in 1984 requires states to automatically certify infants as medically eligible for up to one year, as long as the mothers are eligible, and as long as the babies remain with the mothers.

The Children's Defense Fund Prenatal Care Manual states, "any discussion of state Medicaid options must be divided into four separate issues: eligibility, benefits, provider reimbursement, and methods of administration. Each element profoundly affects the quality of a state's program. Program eligibility options for pregnant women and children are simple: states can provide Medicaid to any pregnant women or child who lives under the state's definition of poverty."[264]

State Medicaid programs must extend coverage to, among others, the following categories of children and pregnant women:[265]

* Children and women who receive Aid to Families with Dependent Children, or Supplemental Security Income benefits.

* Pregnant women who would be eligible to receive AFDC benefits if their children were born and living with them, usually first-time single pregnant women.

* Pregnant women who would be eligible to receive Unemployed Parent benefits were their children born and living with them.

* Any child born after Sept. 30, 1983, and under age five who, on the basis of his family's income and resources alone, would qualify for AFDC, even if the child is living with both parents, and even if neither is unemployed.

These children and pregnant women are known as mandatory categorically needy persons. The low income pregnant women and children who would be covered under the broadest coverage options would include, among others, married women and teens living in two-parent working households. SOBRA of 1986, and COBRA of 1987 made some changes in Medicaid.

Currently 25 states cover all optional categorically needy children under age 18; slightly fewer cover all optional categorically needy children under 21; and 23 states cover all optional categorically needy pregnant women. In addition, "states may provide Medicaid to any of the categories of pregnant women or children if they have slightly too much income and resources to satisfy AFDC financial eligibility requirements, if their funds are insufficient to meet the cost of medically necessary care."[266]

In states that extend Medicaid benefits to medically needy persons, the federal law permits financial eligibility requirements for these persons to be set at 133% of AFDC payment levels. Many states use this standard for families of one or two, but few take advantage of this option for families of three or more persons. "Failure to use the higher financial eligibility standard means that teen women living with their parents will have a more difficult time qualifying for benefits."[267] The Massachusetts statute extends this standard for families of two or more, and may extend it to a family of one. A pregnant woman is counted as if the unborn child were born, and is therefore counted as two.

In 1981, restrictions in Medicaid made it more difficult for low-income women to receive prenatal care. Therefore increases occurred in women receiving late or no prenatal care. Federal cutbacks in the budgets were targeted to low-income families and children, and totaled $10 billion a year for 1982 and subsequent years. Congress has rejected many proposed cutbacks by the current Administration, though further reductions have been made.[268] Programs most affected by cuts were Medicaid, Maternal and Child Health, family planning services, child immunization services, AFDC, food stamps, school lunches and breakfasts, public housing, compensatory education, and day care services. Medicaid provides services for 700,000 fewer children in recent years.

In Families in Peril, Marian Wright Edelman states, "families requiring Medicaid to meet rising health costs have faced barriers, as services have been reduced, and access to care constricted. Expenditures for each recipient child dropped sharply, from $470.91 in FY79 to $406 in FY83. Many fewer children are now eligible when contrasted with the growing number of poor children. Seventy-five children were on Medicaid for every 100 poor children in the U.S. in 1984, down from 99 per 100 poor children in 1976."[269]

Medicaid for Pregnant and Parenting Teenagers

Teenagers disproportionately rely on Medicaid and other federal maternal and child health programs to pay for prenatal health care, labor and delivery, and are therefore more likely to attend clinics.[270]

Pregnant teenagers may have specific problems in obtaining Medicaid coverage. Young women under age 18 who live in a household receiving AFDC are entitled to Medicaid subsidized care. However, they usually have to present their parent's Medicaid card at a clinic, and many teenagers therefore delay the initiation of care rather than confront their parents with their pregnancy. For adolescents living in households that do not receive AFDC, and who are unwilling or unable to obtain their parents' support for prenatal care, the choices left open are often to leave home and establish a separate household in order to receive benefits.[271] In some states, the waiting period for a Medicaid card following pregnancy verification delays early receipt of care. According to Massachusetts advocates, clinics could certify teenagers as eligible for Medicaid through presumptive eligibility, thereby gaining early access to prenatal care for the teens.

Some states issue cards for two month periods, often renewal is difficult, and time constraints often discourages teenagers. Teens in some states may be able to avoid some gaps in Medicaid coverage by virtue of the requirement that Medicaid-eligible individuals under 21 years can receive services through the Early and Periodic Screening, Diagnosis, and Treatment Program.

"While eligibility for adolescents is determined by the general categorical and financial rules governing state Medicaid programs, special attention needs to be paid to the case of pregnant adolescents."[272] One problem that teens have is that some states have attempted to deny AFDC and Medicaid to pregnant adolescents or parents living on their own. This practice has repeatedly been declared as illegal.[273] If a pregnant or parenting teen satisfies the program's categorical and financial eligibility requirements, she should not be denied aid simply because she is considered "too young" to be a parent.

Another serious problem confronting teenagers seeking medical care benefits is when states treat the teens' parents' income as being available to the teens, even when it is not. This practice is known as "deeming". The federal government interprets the Medicaid law as requiring states to deem parent income as available to children under age 21 who live with them. The Department of Health and Human Services takes the position that the federal law does require deeming. Advocates and other groups state that this is arguable - that the law does not require deeming, and that this practice is carried out only because of interpretation. The federal criteria do not require mandatory deeming of parental income to children under 21, but do describe situations in which a state may choose to deem an individuals income not actually contributed to an applicant for the medically needy program in spouse to spouse, and parent to children under 21 relationships.

All states engage in parent-child deeming under their Medicaid programs. Unless the parents' income is low enough to qualify for AFDC, it is very difficult for the minor child to qualify for benefits. Problems are further compounded when families with a pregnant teen cannot or will not contribute to the cost of her support and medical care. Parents of pregnant teens often do not have health insurance for their dependents if they come from lower-income households.

Although the federal government enforces income-deeming between parent and child in Medicaid, it does not permit deeming between grandparents and grandchildren, therefore while the parents income can be deemed to the teen, it cannot be deemed to her unborn child. "Since, in most cases an adolescent has no income of her own, her unborn child becomes legally entitled to Medicaid, which can then be used to cover the cost of the teen's prenatal care."[274] The filing unit is the number of people whose income is counted in determining eligibility.

Massachusetts

There are two groups of Medicaid-eligible teen recipients who may receive Medicaid cards in their own name:

1. The head of an AFDC household may herself by under 21 years of age. Approximately 18% of all teens receiving AFDC are heads of household, or approximately 6% of all AFDC heads of household are teenagers.

2. A small minority of Medicaid clients - about 2.6% of all recipients- are covered under the MA-21 program. This program is for adolescents who are under 21 years and do not have children of their own. Within this group, those adolescents who do not live with their parents have their own Medicaid cards.[275]

The following is a breakdown of eligibility requirements and conditional regulations under which pregnant and parenting teenagers may receive AFDC, Medicaid, and other benefits. A further discussion of AFDC and other public assistance programs is in Section 12. Sources of information are the Massachusetts Department of Public Welfare, and information and fact sheets from the Massachusetts Law Reform Institute.

1. A pregnant teen with no income may receive AFDC cash assistance, a rent supplement if she does not live in public or subsidized private housing, and lives on her own, and may receive Medicaid and food stamps. The teen can apply on her own.

2. Medicaid in Massachusetts is available for all persons under 21, and all pregnant women of any age who are financially eligible. Medicaid can be obtained any time during pregnancy. If income and resources - cash, bank accounts, cars - are below the following amounts, a person may be eligible for Medicaid:

income		resources	
$469	not pregnant	$2,000	not pregnant
$616	pregnant	$3,000	pregnant

If income and resources are above these amounts, a person may become eligible through a "spenddown".

3. If a teen is under 18 and is pregnant and living with her parents, the parents' income is counted when application is made. The parents' income is not counted if the teen does not live with them. (As previously stated, advocates state that this practice is a federal interpretation of the law, is litigable, and subject to challenge.)

4. If a teen is 18 or older and pregnant, the parents' income is not counted even if the teen lives with them. Only the amount of income the parents actually give the teen to live on is counted.

5. A teen parent is eligible for AFDC, Medicaid and Food Stamps if they live alone. If the teen has no income, she may receive $394 a month for 2 people, and a $15 rent supplement if she does not live in public housing.

6. If a teen parent lives with her parents, she may be eligible for AFDC for her baby, and may receive Medicaid for the baby.

7. If the teen is under 18 years, the amount of AFDC received for herself depends on the parents' income and resources. If the parents receive AFDC for the teen and other brothers and sisters, the teen can ask for a separate AFDC grant for herself and the baby, even if she is under 18.

8. A teen mother living apart from her parents is eligible for Medicaid for herself and her child. If she gets AFDC, Medicaid is automatically provided without filing a separate application. If income is over the limit for AFDC, the teen may still be eligible for Medicaid as an AFDC-related unit.

Section 73 of the FY88 budget expands Medicaid eligibility to pregnant women up to 100% of poverty. The section states that a pregnant woman remains eligible throughout her pregnancy and for up to 60 days postpartum, without regard to changes in the family income. Section 74 clarifies certain pregnant and parenting teens as being eligible for Medicaid if they are under 18 and live with their parents. Teens would request services as emancipated minors, and parents would be unaware that services were requested or unable to pay for services. Also, presumptive eligibility would allow specific providers to serve pregnant women for a 45 day period if they appear to be medically eligible, and their application is being reviewed.

According to the Department of Public Welfare's policy, pregnant and parenting teens under 18 who reside with their parents have no independent access to Medicaid programs. Parental income is deemed available to minors regardless of whether it is actually contributed, whether the parent is aware of the care sought by the teen, or whether the parent consents to pay for such care. The state Medicaid statute, Ch. 118E, does not specifically state conditions regarding deeming of parent income for pregnant and parenting teens who, although they may be eligible for Medicaid as children under age 21, may also be independently eligible as pregnant women, or as the parents of dependent children.

Advocates have been working on several areas concerned with eligibility for teens and their children for Medicaid. One area is that of pregnant and parenting teens under 18 who live at home. Advocates believe that the income and resources of the parents should not be counted, especially in situations where the parents are not aware of, or refuse to financially assist with, pregnancy care. The Department of Public Welfare refutes this position, and believes that income should be deemed.

The Department does recognize that certain minor children who may be emancipated, would have their parents' income disregarded, even if the minor lives with them. The Department recognizes only the following as being emancipated minors:

1. an individual under the age of 18 who is married, separated, or divorced

2. has served in the armed forces

3. a person emancipated by the court

Pregnant and parenting minors are not included in this definition, therefore the Department counts the income and assets of the minor's parents as being available to the minor when she lives with them.

There is a state law in Massachusetts, Chapter 112, s. 12F, which allows pregnant and parenting minors the right to seek their own medical care, without parental consent, excluding abortions and sterilizations. The legislation eliminated the requisite for parental consent, and provided that parents would not be held financially liable for any care given under this statute. Advocates have been working on this issue, stating that this law should entitle eligible teens to the right to Medicaid benefits on their own, whether or not they live with their parents. Legislation has been filed addressing this area. Advocates are working on the rights of pregnant and parenting teens to have access to their own Medicaid cards, independent of their parents, and to not have the policy of deeming of parental income.

The federal Consolidated Omnibus Reconciliation Act, COBRA, signed into law on April 7, 1986, provided for a large number of changes in the health care of pregnant women, and covered Medicaid, Medicare, and employer-provided health insurance.

The Medicaid Program financial eligibility levels for families are still 15-23% below the federal poverty level.

Medicaid covers health costs for about 575,000 Massachusetts citizens. According to the Department of Public Welfare, many obstetricians in communities with excessive infant mortality rates refuse to participate in Medicaid despite a 24% increase in fees for prenatal care and delivery. According to the Department, 1 physician out of 3 refuses to participate, with a 33% statewide refusal rate, and some areas of the state having higher rates.

The Department of Public Welfare offers two health care programs:

Project Good Health: This is the EPSDT program in Massachusetts, and is a preventive health care program which offers comprehensive and continuing health care to Medicaid recipients under age 21.

The Coordinated Health Program: A coordinated approach to service delivery which offers health care through community health providers and health maintenance organizations.

In 1984, 5.5 million poor and near-poor women had no health insurance, and the numbers are increasing. In 1984, the total costs for births not covered by Medicaid or private insurance was $2.5 million.

Recommendations

Medicaid has been shown to have a substantial impact on the health status of children. Several studies[276] have identified state Medicaid policies for pregnant women and children as having played a significant factor in the reduction of neonatal and infant mortality rates since 1966. Other studies examining children's participation in Medicaid's comprehensive preventive health program - EPSDT - have found that children receiving preventive services exhibit fewer abnormalities at periodic examinations than those who do not receive such benefits.[277]

Medicaid services have proven to be cost-effective. Studies have shown improved health outcomes for babies whose mothers were enrolled in projects, and a savings of $2.00 for every $1.00 spent on prenatal care in the first year alone. Studies of the EPSDT program have shown that overall costs for children participating in the program are significantly lower than for those who did not participate.[278] Few states, including Massachusetts, make creative use of this program.

The Children's Defense Fund has given the following recommendations for the improvement of the Medicaid program. Some of the recommendations have already been adopted.[279]

1. Improve Medicaid eligibility for pregnant women and children by broadening the state's categorical eligibility requirements, which are the criteria a state establishes to determine which categories of pregnant women and children are eligible for benefits.

2. Liberalize the program's financial eligibility requirements. Because Medicaid is linked to eligibility for AFDC, raising the state's AFDC payment levels and standard of need could add thousands of women and children to the Medicaid program.

3. Another way to strengthen the Medicaid Program's financial eligibility standards for medically needy pregnant women and children is to shorten the accounting period used in the program. This is the period of time against which a medically needy applicant's excess income is compared to his or her medical expenses. The shorter the accounting period, the less excess income the applicant has to meet necessary medical expenses and the sooner he or she gains medical eligibility.
   In some states, the accounting period is one month; in others it is up to six months.

4. Improvement through liberal reimbursements to comprehensive health clinics providing a wide range of services to medically eligible and ineligible teens. Low reimbursement levels deny clinics badly needed revenues which could be used to expand the types of services they offer and to provide

4. care at free or reduced cost levels to the near-poor who have incomes slightly above Medicaid eligible levels, but who cannot afford care. Levels that are too low have been stated as illegal, as federal regulations require that a state's Medicaid programs must set provider reimbursement rates at levels that will attract a reasonable number of providers to the program. This would make services as available to Medicaid recipients as they are to private patients.

5. Pass legislation to permit states to raise the Medicaid eligibility cut-off to the federal poverty level in the case of maternity and infant coverage, even though state welfare levels may be lower.

6. Revise the medically needy component of Medicaid to include a new maternity benefit package to be offered to women with family incomes at 100-250% of the federal poverty level. Under current law Medicaid coverage cannot begin until women have incurred high cost bills for services already provided.

7. Development of specific eligibility rules for adolescents to provide Medicaid coverage for those whose personal income is less than the federal poverty level.

8. Simplify and speed up the Medicaid application process.

9. Establish uniform maternity benefit packages that will guarantee quality care.

10. Increase other public health programs.

11. Initiate a study group that would look at options to expand and improve maternal coverage in private insurance.

According to the Children's Policy Information Project, "while the overall health status of children is excellent, there are specific areas where several problems remain...infant mortality rates among blacks and other minorities, child injuries, and suicides are unacceptably high."[280] Children are the least well-insured segment of the population, and are also the ones who are the least-appropriately insured because of what they need - acute and preventive care services.

Health is a very important aspect of child development and crucial to school attendance, performance and behavior. It also affects future employment and lifestyles of today's children, who are an important social investment. There will be fewer children in the future, relative to the number of older persons that they will need to support.[281]

"The political status of children will always have to be represented by proxy, and they will never have a political status in their own right. The health care insurance system is not designed to meet the needs of children."[282] Local communities have had great difficulty in trying to compensate for cutbacks at the federal level. This has had, and will continue to have, a direct effect on the health status of children, who need specialized health services.

Childhood inuries remain the leading cause of death in that age group since the early 1900's. Adolescents and young adults, ages 15-24, suffer death rates that are much higher today than they were 20 years ago. Nearly 80% of all deaths in this age group are the result of injuries, homicides, and suicides.[283] Deaths in this age group are "largely a social and developmental problem and very few of them are from specific medical problems."[284]

In the first year of life, about 2% of children who are born will end up with severe impairments of some kind. A far greater percentage, at least 20%, will have at least one major health problem within the first year of life, and one child in ten will be hospitalized during the first year of life.[285] Illnesses tend to cluster in certain children. Children with one health problem tend to have accompanying other health problems, in both minor and serious illnesses. Other children need more traditional broad-based public health approaches that address the major health risk factors in childhood.

Equalization of access to health and medical care has been documented as having a positive effect on child health.

While cost-effectiveness studies, and cost breakdowns and comparisons are stated throughout this report, there are some health-related costs that are stated here.

Studies have indicated that for each $1.00 invested in preventive health care, there is a $2.00-$3.00 savings in consequential costs. The average cost of caring for a low birthweight baby in a hospital intensive care unit is between $10,000 to $15,000.

According to the Boston Committee on Access to Health Care, "....of the 4,600 annual low birthweight babies in Massachusetts, some 340 are disabled to the point of requiring specialized and long-term care services. Massachusetts costs per year for these babies probably amount to between $9 million and $26 million, depending on whether the child is in a nursing home at $26,000 a year or in a state school at $75,000 a year. By the age of 21, these children will have required services costing between $189 million and $54 million. Like neonatal intensive care costs for the near-poor, these costs are generally incurred by the Commonwealth."

The Health Insurance Association of America states that 1982 costs for un-

complicated deliveries were $2300 for each delivery, and costs for a cesarean delivery were $3600 each delivery. In 1985, an uncomplicated delivery was $3200, and a cesarean delivery was $5,000.

Teen parents and their children frequently need foster care placements and group care or residential placements for both mother and child, special education for both mother, and often long-term for children, shelters, services for runaways and their children, substance use and abuse treatment programs, and other costs associated with adolescents and the problems they are experiencing.

In terms of human and financial costs and expenditures, the short and long-term impact and consequences of early pregnancy and childbirth are immeasurable.

The cost of a teenage mother who is a female head of household and one child for one year, receiving AFDC, food stamps, and Medicaid, is nearly $9,000.

In the United States, in 1975, $8.5 billion was spent on federal AFDC, Food Stamps, and Medicaid programs for pregnant and parenting teens and their children. A decade later, in 1985, this figure had nearly doubled, approaching $16.6 billion.

In Massachusetts, the yearly costs of AFDC, Food Stamps, Medicaid for teenagers, and one dependent (many teen parents have more than one child) average $39,500,000. When costs are factored in for dependents only, pregnant teenagers, social services, health services, and other such programs, the costs are $55,000,000 million. These figures do not include those teens who are on their mother's grant, costly medical and other health expenses, foster care, special education, and other services often needed by this population.

Children are among the most vulnerable members of our society. They are also our future strength. Any investment in prenatal care, health and preventive health services for children and teenagers is crucial to building a sound foundation and healthy prospects for their future.

While many programs presented and discussed in this report contain health components, or have as a main focus health services, even if located in a school, or other site, several health programs will be discussed in the following pages.

Healthy Children

Healthy Children is called a Program to Encourage the Development of Children's Health Services. Many children of teen parents are the target of these programs.

Dr. Philip Porter, of the Division of Health Policy Research and Evaluation, Harvard University, began a program in Cambridge, Massachusetts twenty years ago, to address the deficits in health care services for children in that community. The program was later launched on a national scale to identify models of care that were as effective as the Cambridge model. Another goal was to stimulate communities throughout the country to take similar action for their children. Some funding for these efforts came from the Robert Wood Johnson Foundation.

In his manual, Healthy Children: A Casebook for Community Action, Dr. Porter discusses the national challenge of medically disadvanteged children, and presents a casebook of an analysis of some existing successful programs. These programs are accessible to all children from low-income families. These programs have improved accessibility and health status for these children, and have proven themselves to be cost-effective. The manual also gives a community questionaire designed to assess health services by type, along with day care services and other programs. The manual also gives a statement of the problem, and potential solutions in the areas of school-based primary care, handicapped children in rural America, social enrichment, and primary care for preschoolers, teenage pregnancy, comprehensive primary care for mothers and children. Profiles of the programs in Cambridge, Gainesville, Florida, Great Barrington, Mass., St. Paul, and Sarasota, Florida, are discussed.

Michigan, Ypsilanti, The Corner Health Center

This program was developed by community leaders in response to specific needs of adolescents in the Ypsilanti area. Goals of the program are;

1. To offer a broad range of basic health care services and health education for teenagers and their children, if they have them.

2. To offer and provide education and knowledge, and applicability in reproductive health. Ypsilanti area teens have higher birth rates and their babies have higher infant mortality rates than the rest of the county.

3. To offer health care services and health education which stress pregnancy preyention, and which include comprehensive primary health care for adolescents and their children.

4. To provide services and educational programs that are school-based and multiserviced.

During the year 1983 to 1984, two additional health education programs were established in high schools, and further expansions were made in 1985, and continue in educational programs and health services. Client numbers have increased.

An advanced theatre group has been established. Student Health Advocacy Boards were established in two schools, and high school students design and carry out peer health promotion program.

As patient visits increased, with an increasing demand for services, financial support was given by the Michigan Dept. of Public Health for another clinic session, increasing sessions from 14-16.

The clientele of the program consists largely of teenagers 15-19, with a high concentration between the ages of 17 and 19. The population is white and black males and females.

Pregnancy prevention is a major priority. Family planning fees remain constant and are designed to encourage the use of preventive health services while demonstrating that prevention is cheaper and more effective than treatment of unplanned pregnancy.

Other program components, with effectiveness studies stated where they have been conducted, are:

Peer Education Program: Provide family planning education, counseling, other services and group sessions. Peer educators are trained.

A special concern of all programs are the prevention of subsequent pregnancies

Pregnancy Care: Pregnancy diagnosis and counseling; comprehensive care. Interagency cooperation provides continuity of care and follow-up.

Follow-up study: Of all babies whose mothers received prenatal care at the Corner, none was born with low birthweight and none had birth defects.

Pediatric Care: Offers the opportunity to stay in contact with young mothers and teach them about parenting and child care, encourage school continuation and delay repeat pregnancies, and follow teens' emotional and medical needs.

General Medical Care; Physical examinations, screening, immunizations, treatment of health problems.

Social Services: Clients referred to counseling, social workers, agencies, and other resources as needed. All clients meet with social worker on family adjustment issues, preparation for parenting, other needs.

Referrals are made to WIC, DSS, public assistance, day care centers, educational resources.

Teen Parent and Peer Educators; Trains 13 teen mothers, with 8 hired to serve as peer educators in the clinic, schools, and the community. This component is an important philosophical component of the program. Special attention is given to problem solving and vocational guidance.

Home Visits

Student Health Advocacy Boards: Funded by Michigan Dept. of Public Health. Encourages students to plan and carry out school-wide activities about teen health issues. Working in pairs, students are given teen problem situations and required to find appropriate agency to help solve problem. Students give workshops and presentations.

Outreach Education: Programs in schools, communities, universities; provide education, presentations, discussion groups.

Statistics:

The Corner's Educational Programs reach nearly 10,000 youth, an increase of 153%.

Patients over the past year made nearly 3,000 medical visits, an increase of 24%.

Pediatric services grew slightly, and accounted for 12% of visits.

Peer educators made 29 educational presentations to over 1,000 teenagers.

Family planning clientele increased, accounting for over 1,000 patient visits.

Pregnancy care accounted for 25% of patient visits; The Corner diagnosed 144 pregnancies in one year.

Over 2,000 students participated in Board sponsored activities.

Follow Up Study: Pediatricians reviewed charts of 167 babies who had received pediatric care. The sample was divided into three groups: those whose mothers had received no care at the Corner, those whose mothers had received gynecologic care at the Corner, and those whose mothers had received prenatal care at the Corner. A subgroup was identified whose mothers had received prenatal care at the Corner. Results indicated that of all babies whose mothers had received prenatal care at the Corner, none was born with low birthweight and none had any discernable birth defects.

Funding and Financial Data:

75% of patients were low or very low income status.

50% of pregnant patients were covered by Medicaid.

Medical care is provided at low cost, but not free. A sliding fee scale is used.

48% of the patients fell on the lowest end of the sliding fee scale and paid minimum fees.

Low cost medical care and social services are made possible by many in-kind donations of services from the Univ. of Michigan Hospitals, Public Schools, and volunteers.

150 volunteers donated approximately 3,000 hours of service.

The United Way funds part of the programs; $10,000 in medical supplies was contributed by drug companies and others.

Donations from charitable foundations amounted to 9% of revenues; fundraising raffles accounted for $1800 in revenue.

According to a letter from the Director of the Corner Health Center, Dr. Joan Chesler, to the Task Force, there are some schools in the county that do provide day care, and teen parents and their children are bussed to and from school. Dr. Chesler also states that pregnant and parenting teens are identified in the community, and referred back to their schools for re-entry, if they have dropped out. Dr. Chesler also stated that they are conducting further follow-up studies on their populations, but that these studies can be costly and require financial assistance and additional staff, or outside evaluation efforts.

The Corner Health Center, 210 W. Cross, Ypsilanti, MI 48197, 313-484-3600,
Dr. Joan Chesler, Executive Director

New York, New York, Young Adult Clinic

Presbytarian Hospital, in conjunction with Columbia University's Center for Population and Family Health, opened the clinic in 1977. It is based in the inner-city, in a predominantly Hispanic neighborhood with specialized services for teens who need family planning services, as well as venereal disease control, pregnancy testing, cancer screening, and gynecological care. Clinic sessions are held in the evening, in addition to during the day. The average attendance rate is 40-50 per session. The Clinic is designed to eliminate many barriers that traditionally deter sexually active teens from seeking preventive health care.

Over the years, the clinic has made use of many creative outreach strategies to bring in new clients: health/sex educators in the schools and informal community settings, peer education teams, peer counselors, a theatre group, bilingual adult advocates, and a young men's program.

The Columbia School of Public Health developed a program that builds community awareness of the risks of adolescent pregnancy and educates sexually active teens about pregnancy prevention. Health educators work in schools and informal settings, and promote links with community groups, parents, teens, and churches.
Excerpted from Children's Defense Fund. Young Adult Clinic, Presbytarian Hospital West 168th and Broadway, 4th floor, N.Y., N.Y. 10032, 212-305-6960.

Missouri, Kansas City

A school-based clinic was established in Kansas City in 1983. A survey was conducted between May, 1983 and May, 1985, to compare the general health and health care needs of the students before and after the establishment of the health clinic in a local high school. The following are the results of the survey:

Substance Abuse: Of those who used substances, alcohol and marijuana were the most widely used. The 1985 students had a lower usage percentage.

1985 - 80% never used alcohol
1983 - 70% never used alcohol

1985 - 86.5% had little or no use of marijuana
1983 - 77.1% had little or no use of marijuana

Sexual Activity: About the same for both years.
70% had sexual intercourse at least once.

Birth Control:

1985 - 30.9% used some and 14.9% used it all the time
1983 - 23.9% used some and 12.8% used it all the time

Pregnancy:

1985 - 10.4% pregnant: 5.8% had given birth
1983 - 11.0% had been pregnant; 8% had given birth

Feelings: 1985 respondents were more likely to feel good about themselves, hopeful about the future, and less likely to think about ending their own lives.

Clinic Users vs. Non-Clinic Users: 45.4% of the respondents had used the clinic and were in excellent health compared to the 39.2% non-users. Clinic users were more likely to have visited a doctor and dentist in the past year. Clinic users had better eating habits. Clinic users were more likely to use birth control-55.1% users vs. 34.9% non-users.

Washington, Seattle, Adolescent Clinic

The Adolescent Clinic is an interdisciplinary health care facility that is part of the University of Washington. It was established in 1957, and offers a wide variety of physical and mental health services to teenagers and their families. The Clinic's services are directed toward teens with multiple physical and mental health needs who otherwise could not be served at a single site.

University health care professionals and graduate-level trainees provide comprehensive team-coordinated assessment, treatment, and follow-up services. Some of the clinic focus are: substance abuse, family conflict, eating disorders, teen pregnancy, birth control, learning disabilities, and sexual identity. Health care specialties include medicine, psychology, social work, nursing, nutrition.

The clinic serves between 450 and 500 young people each year, which translated into about 5,000 contacts a year.

The Clinic has 24 hour emergency services, and four specialty clinics:

The Young Women's Clinic: comprehensive care for pregnant women age 16 and younger, with involvement of male partner and other support persons.

Teen Weight Management Clinic

Clinic for Alienated Youth; Support for parents and youths who are in conflict; focus on youths who have dropped out and spend increasing time away from home and school.

Disabled Youth in Transition: Services for youths who are 17-21, about to finish school, and who have chronic or lifetime disabilities.

Fees are based on services provided and are adjusted on a sliding scale that maximizes the availability of the clinic's services to low income youths. Medical coupons and third-party payment are also accepted.

Excerpted from Children's Defense Fund. Adolescent Clinic, Univ. of Washington, Seattle, Washington 98195, 206-543-8705.

Introduction

The following pages contain descriptions of health programs in Massachusetts, and a directory of services and programs in the state. Areas of the state have been broken down wherever possible by Health Service Area, Social Services Region, Service Delivery Area, and Education Program areas. At the beginning of each Health Service Area is a map of that area, and a list of the cities and towns, along with teen birth data for each city and town for 1984 and 1985, the most recent years for which statistics are available. The total teen births for each year for a particular Health Service Area is stated on the list of cities and towns. The numbers of pregnant and parenting teenagers serviced each year for a program or service, are stated in the summary wherever that information is available. Programs and services are listed alphabetically under a city or town. It should be noted that some pregnant and parenting teenagers may be seen by more than one agency, and therefore may be counted more than once in the numbers serviced.

Those programs that are part of the Department of Public Health, Division of Family Health Services MAPPS study, are designated as such. The Comprehensive Adolescent Health Programs are designated as CAHP beside the programs that are part of this study. Those that are part of the Pregnant and Parenting Adolescent Programs are designated as PPAP. These programs are discussed in the Health Services Section.

While Health Service Areas, Social Service Regions, Service Delivery Areas, and other area designations are not equally delineated by each agency, they are similar and are compatible, though some areas overlap others, and some exclude cities and towns that may be included by the way one or another agency delineates their area boundaries. The areas are defined according to agency designations, and are presented according to these designations as closely as possible.

Recommendations stated in the surveys are summarized at the end of each Health Service Area. Recommendations are stated at the end of this report, by category.

The Task Force has made every effort and attempt to obtain information on, send surveys to, and contact all service providers, agencies, programs, groups and organizations across the state. This search has been conducted over a period of several months. While every effort has been made to obtain this information, the Task Force is aware that, through an oversight, an agency or program may not be included in the report. If this has occurred, the Task Force would very much appreciate it is agencies or programs would send information on their program, or contact the Task Force. Some agencies were sent several surveys, and did not respond.

Pregnant and Parenting Teenagers Questionaires

Over 2,000 questionaires have been sent out across the state to service providers, agencies, and groups who agreed to participate in surveying pregnant and parenting teens in their caseloads. The questionaires were, in turn, given to teens to be filled out and returned to the provider or agency. The questionaires are anonymous, but the client was asked to fill out the city or town in which they lived. Therefore categorization according to Health Service Areas, Social Service Regions, Public Assistance Areas, Service Delivery Areas, and School Districts, is possible.

Many questionaires have been completed and returned to the Task Force. Teens

answered the questionaires themselves. These are currently being analyzed, and results will be in a forthcoming report when analysis and evaluation are completed. Some preliminary findings have been stated in this report. Hundreds of questionaires are currently being completed, and service providers and agencies are still requesting questionaires to be used with their teenagers. Many service workers who have completed and returned the questionaires reported that the questionaires provided some information that was beneficial to those working with the teens.

There are several questions that are reflective of the needs, plans, and concerns of pregnant and parenting teenagers. While the responses to the questions are not specific recommendations, they are indicative of the conditions, situations, and needs of this population and their children, as experienced and expressed by them. These expressions of need are also real and potential targets for preventive-interventive strategies with these teens and their children.

The questionaires have been received from urban, rural, and moderately-sized communities, cities and towns, and are representative of varied geographical locations and populations. However, some ethnic groups are not adequately represented, as the questionaires are not translated into their native language. Some questionaires were filled out by bilingual Spanish-speaking clients; others were translated by the service providers or representatives of the agencies. A Spanish version of the questionaire is being developed for distribution.

A few service providers were unable to participate in the study, either because they experienced a staffing shortage, or only saw the teenagers sporadically, or for brief periods of time. Also, some providers were at the beginning stages of their programs, and did not yet have many clients.

Surveys of Programs and Services

Throughout the meetings of the Task Force conducted since early 1985, representatives of many agencies, service providers, programs and services, groups and organizations, participated in the meetings and gave presentations on their programs, service components, populations they serviced, proposals for expansion of programs, new initiatives, collaboratives and networks that had been formed, or are in the planning stages. Participants stated their needs, concerns, and recommendations. Models were also presented, along with any research data that had been collected and analyzed regarding numbers of clients, follow-up information, community and school outreach to students, parents, and others who had attended, or been involved in the service delivery, and outcome information, if this was available.

Representatives of the groups, programs, and service providers identified the various needs of their community, discussed formation and implementation of networks and task forces, if these had taken place, and discussed the particular populations they serviced. Many agencies and service providers are unable to conduct research and effectiveness studies due to lack of funding, staffing, and other such resources. Discussion periods followed each presentation, with question and answer periods.

Reports, brochures, plans and proposals, studies and other relevant information was collected from members of the Task Force, from agencies, and service providers. Participants came from many different areas of the state.

In July, 1986, the Task Force sent out surveys to agencies, service providers,

groups and organizations across the state, in order to obtain a uniform assessment of all programs and services that are either available, or in the planning stages. A sample of the survey is at the end of this section. Questions pertained to the types of services, location of services - whether on-site, or done on an outreach basis in the schools, community, and other locations. Many agencies conduct services at their own site, and outreach in multiple sites. This is stated in the summary of the services provided by the agency. Other questions related to the number of pregnant and parenting teenagers serviced, collaboratives and networks with other agencies, recommendations, sources of funding, and other relevant information. If an agency stated on the survey that they worked with another agency, that agency was also sent a survey, if none had been obtained by the Task Force. Many agencies are expanding on existing programs by adding new components, or new initiatives, or are forming linkages with other agencies. The surveys also state whether or not an agency provides services in one site, or at multiple sites, and where these sites are located.

Many programs are multi-service and have interdisciplinary components. While health services may be viewed in their broadest sense to include any type of service related to the health, mental health, social and emotional health and well-being of this population and their children, areas and sections are broken down into Health Services, Social Services, Mental Health Services, Public Assistance Programs and Services, Educational and Vocational Education Programs and Services, and Job Skills and Employment Training Programs and Services, and Day Care Services, Child Support Enforcement, and Family Life, Sexuality Education and Human Development Programs. Some agencies designated as a health agency may contain many other components, and therefore appear in more than one section. An example would be a community-based program that provides health services, education, day care, and other components.

Recommendations by Service Providers, Agencies, Groups and Organizations

Recommendations from service providers, agencies, and others working with pregnant and parenting teenagers are stated at the end of each Health Service Area.

While there are other service providers, agencies, advocacy groups, and legislators working on issues and recommendations relating to pregnant and parenting teenagers, or on issues that would impact this population, the recommendations stated at the end of each HSA are based on returned surveys only, and are presented as they are stated on the surveys. Most surveys contain several recommendations, not necessarily in priority order. Recommendations are counted in the results by the number of times they appear, and are stated on the surveys. Some recommendations may be stated differently, but have the same meaning, or approximately the same meaning. Those that mean the same are grouped and counted as one recommendation, wherever it was determined that the meanings were exactly the same. If it was determined that there was a slight variation in meaning, both recommendations are stated or clarified, and are counted as separate recommendations.

Some areas have only a few surveys, reflecting the small number of agencies and providers of services to pregnant and parenting teenagers. Some providers did not make any recommendations.

While it is difficult to assess the full needs of this population from a small number of recommendations, it is important to state these recommendations, and the precentages, as indicative of the needs and priorities of these areas. In some areas, networks, task forces, coalitions and collaboratives have been formed, or are in the planning stages, or are in the process of being implemented. Four areas, Lawrence, Chelsea, Springfield, and Fall River have formulated Action Plans for their communities. These Plans have been printed and contain the network of agencies involved, their purpose and goals, goals and objectives of the Action Plans, identification of needs of their varying populations, plans for implementation, and recommendations for planning and programming, and policymaking. The recommendations presented in each Action Plan report are stated in the appropriate area having the Action Plan.

As the Task Force is still in the process of identifying service providers and agencies servicing this population, and is gathering surveys from those identified, more recommendations may be forthcoming when these are returned. Also, recommendation percentages and counts may be higher in some areas when all surveys are returned. Most surveys have been returned from all areas of the state. However, there are still a few surveys remaining to be returned. These will be added to this report in future updated revisions. All recommendations of all Health Service Areas are stated in the final Recommendations Section.

It should be noted that recommendations should not be considered as competative of one another, or as one recommendation identified in the surveys as being more needed than others, or as more important than others. Recommendations are stated as they appear on the surveys, and percentages are stated by the frequency with which they appear on the surveys.

MASSACHUSETTS CAUCUS OF WOMEN LEGISLATORS
TASK FORCE ON PREGNANT AND PARENTING TEENS

REPRESENTATIVE PATRICIA G. FIERO, CHAIRPERSON

SURVEY OF SERVICES AND PROGRAMS

NAME OF AGENCY: _____

ADDRESS _____

PHONE _____

FUNDING SOURCES: (Public and Private) _____

_____

NUMBERS OF TEENAGERS YOU SERVICE EACH YEAR. PREGNANT _____

PARENTING _____

PROGRAM COMPONENTS: SERVICES YOU PROVIDE TO PREGNANT AND PARENTING TEENS

_____

_____

_____

_____

_____

_____

OUTREACH PROGRAMS YOU PROVIDE: COMMUNITY _____

SCHOOL _____ ON SITE _____

COUNSELING, PARENTING SESSIONS, INDIVIDUAL AND /OR GROUP _____

PREGNANT AND PARENTING SESSIONS _____

PARENTS OF PREGNANT AND PARENTING TEENS _____

COLLABORATIVES WITH OTHER AGENCIES, SCHOOLS, CHURCH GROUPS, ETC.

_____

_____

OTHER ADOLESCENT SERVICES _____

_____

DO YOU KNOW OF ANY PRIVATE AGENCIES IN YOUR AREA WHO SERVICE PREGNANT AND PARENTING TEENAGERS? PLEASE LIST

_____

_____

_____

_____

TYPE OF STAFF PROVIDING SERVICES _____

_____

DO YOU CHARGE A FEE FOR YOUR SERVICES? _____

_____

_____

PLEASE STATE RECOMMENDATIONS FOR SERVICES AND PROGRAMS YOU WOULD LIKE TO HAVE IMPLEMENTED IN MASSACHUSETTS

_____

_____

_____

PLEASE SEND US ANY INFORMATION YOU HAVE DESCRIBING YOUR PROGRAM.

THANK YOU FOR YOUR HELP.

Teenage Pregnancy Prevention Challenge Fund

In January, 1987, Governor Michael S. Dukakis launched the Challenge Fund, which was created to help communities to either plan a comprehensive strategy to prevent teen pregnancy or to implement such a plan. For FY88, the Challenge Fund received $1.2 million in appropriations from the State Legislature, and is being administered through the Executive Office of Human Services.

The fund encourages local communities to address the problem of teen pregnancy prevention by developing local plans and initiating comprehensive pregnancy prevention services for adolescents. The fund would make financial resources available to communities to initiate new services directed at prevention of teen pregnancy. These services would be identified in the local action plan. Funds would also provide technical assistance to local communities in developing the plan. Assistance would also be given to coalitions that would include community advocates, teens and parents, school personnel, health and human service providers, church and business leaders and local officials.

Examples of prevention services include: case management; education of parents of teens; peer support and health education; leadership programs; youth theatre groups; public education efforts; information/referral; coordination of services; career exploration and development; self-esteem building programs and general and preventive health services.

Decisions to provide funding for planning are based on a community's need and commitment to solve the problem. Funding is provided for support to convene a local coalition, map out existing programs and services, develop a comprehensive Action Plan, and identify potential resources to implement the Action Plan. Factors that will be used to determine a community's readiness will include: membership of the coalition, scope of the plan, proposed coordination of services, innovation and creativity in program design, and support throughout the community for the implementation of the plan.

Community agencies may get together to develop a planning proposal, with one agency administering the planning funds. A proposal for implementation of the funds must be submitted by a community coalition. The coalition must choose a lead agency that will administer the funding and provide ongoing coordination and planning. The lead agency may either directly provide the new or expanded service, or subcontract with other agencies.

Funding for planning will range between $20,000-$50,000, and funding for implementation will range from $50,000-$200,000. Challenge Funding is available for no more than 50% of an Action Plan. The Action Plan should include existing programs or new local and/or private sector support. Each Action Plan should document the problem, describe existing services, identify gaps in services, propose ways to prevent pregnancy among teens, and propose ways to help teens better access services. The funds may be sued for planning, coordination, outreach, and case management.

Recognizing that each community's resources and solutions vary, the Governor's Office on Women's Issues, with the Executive Office of Human Services and the Department of Public Health, provide technical assistance to four Massachusetts coalitions: Chelsea, Fall River, Lawrence and Springfield (described in listings of programs under appropriate Health Service Area). Action Plans have been formulated in these four areas.

In September, 1987, Human Services Secretary Philip W. Johnston accounced the

14 communities that received funding to develop and implement plans to prevent teen pregnancy. These communities, and the amounts awarded to each, are listed on the following pages.

Implementation Awards

Lead Agency	Community	Amount
Center for Human Development	Springfield	$ 216,836
CARE	Holyoke	100,000
North Suffolk Mental Health Association	Chelsea	136,884
Citizens for Citizens	Fall River	60,000
Lawrence General Hospital	Lawrence	185,816

Planning Awards

Lead Agency	Community	Amount
Alliance for Young Families and Consortium of Black Health Directors	Boston	$ 60,000
City of Somerville Dept. of Human Services	Somerville and Cambridge	30,000
City of Cambridge Dept. of Human Services		
Department of Public Health	Worcester	30,000
Montachusett Opportunity Council	Fitchburg	30,000
Community Action, Inc.	Haverhill	30,000
DARE Family Services	Taunton	30,000
Brockton Area Private Industry Council	Brockton	30,000
Human Services Dept.	Hampshire County	30,000
Berkshire Area Health Education Center	Berkshire County	30,000

Other Program Components

Administration	$ 98,475
Overhead and Support Costs	
Centralized Teen Pregnancy Prevention Media Campaign	50,000
Centralized Challenge Fund Evaluation	50,000

One million dollars from the Challenge Fund will go directly to communities. The remaining $200,000 will fund technical assistance for the communities, a statewide information clearinghouse on teen pregnancy, a statewide media campaign, and a three-year evaluation of the Challenge Fund to identify which programs and models are most effective.

All program proposals are reviewed by the Coordinating Council on Adolescent Health Care, established through legislation sponsored by State Representative Patricia G. Fiero, and enacted in December, 1986. The Coordinating Council will be discussed in the following pages. The Secretary of EOHS will make all final funding decisions.

Executive Office of Human Services, Sheri Adlin, 1 Ashburton Place, 11th floor, Boston, Ma. 02108

Coordinating Council on Adolescent Health Care

In December, 1986, Legislation sponsored by State Representative Patricia G. Fiero (D-Gloucester) was enacted on Chapter 643, An Act Establishing a Coordinating Council on Adolescent Health Care. The Council consists of members and commissioners from the Departments of Public Health, Education, Public Welfare, Social Services, Mental Health, Youth Services, the Director of the Office for Children, the Secretary of the Executive Office of Human Services, the Secretary of the Executive Office of Economic Affairs, and seven members to be appointed by the Governor, four of whom are representatives of nonprofit organizations that provide advocacy or services to adolescents.

The Council reviews proposals submitted for funding from the Challenge Fund. Other activities of the Council include:

1. compiling and disseminating information on existing programs, and resources - nationally and in the Commonwealth

2. determination of met and unmet adolescents' needs statewide

3. provide planning and technical assistance to local and regional areas

4. develop model programs and service networks that would address and meet adolescent needs

5. encourage and support the development of community-based task forces; promotion of coordination among existing services

6. encourage the development of new programs and initiatives that would create uniform quality in service delivery

7. request that each agency to determine the nature, scope and impact of pre-adolescent and adolescent needs

8. help programs to plan and implement maintenance and follow-up of teens in servicing programs; conduct effectiveness studies

9. determine the social, economic, educational, physical and psychological impact and consequences of adolescent pregnancy and parenting

10. evaluate and determine potential sources of private and public funding

11. provide substantial recommendations for prevention and intervention services, and the implementation of services

12. promotion of positive behaviors in all aspects of adolescent development and growth, including self-esteem, educational attainment, job and vocational training and education; reducing teen pregnancy, low birthweight in infants and infant mortality

13. promotion of health care for pregnant and parenting teens and their children

Massachusetts Coalition for Pregnant and Parenting Teens

The Coalition is a statewide coalition of public and private agencies, service providers, and indivíders, and individuals committed to improving services for pregnant and parenting teens.

The Coalition began in the spring of 1981. Three basic goals are:

1. promote public awareness of issues pertaining to teen pregnancy and parethood

2. advocate on behalf of pregnant teens and parenting teens

3. promotion of resource and information sharing among agencies serving this population

Members of the Coalition include human service agencies, schools, hospitals, neighborhood centers, local networks, public state agencies, administrators, nurses, social workers, researchers, business people, and educators. Members of the Coalition have served on many state task forces. The Coalition seeks to expand supportive activities with member agencies, and to work with other state and local groups to get community-based comprehensive services for pregnant and parenting teens throughout the state.

According to an article in Urban Resources, Vol. 3, No. 2, Winter, 1986, titled, "Adolescent Pregnancy and Parenting Programs in Massachusetts", "Developing and implementing comprehensive services for young school-aged mothers will require the advocacy and creative efforts of many individuals in many sectors of the Commonwealth, since this goal will not be reached until health care, education, social services, employment, day care, and housing are all equally accessible to teenage parents and their children." The Coalition has recently released

a pamphlet, "Massachusetts Teenage Childbearing in a Regional and National Context", which provides graphs and statistics in the areas of poverty, prenatal care, out of wedlock births,

Alliance for Young Families

The Alliance is a non-profit consortium of service providers, that receives funding primarily from foundations. In 1983, the Alliance initiated a task force that consisted of 30 representatives of public and private agencies in Massachusetts. In the spring of 1985, a report was issued, "Uncertain Futures: Mass. Teen Parents and Their Children." The report stated 13 specific recommendations to ensure access to vocational and employment and other programs.

The Alliance has expanded to 57 health and human service agencies in the Boston area. A major goal is to increase and improve the availability and accessibility of quality remediation and prevention services and opportunities for pregnant teenagers and young families. To accomplish this mission, the Alliance initiates programs to:

* plan coordinated approaches to the service needs of this population
* advocate for changes in public policies affecting pregnant teens and young families
* improve the quality of existing services through provider education, interagency collaboration, and member services
* develop model service programs to increase the availability of needed resources

The Alliance operates the following programs:

1. State Policy Advocacy Program: To advocate for policy changes at the executive, administrative, and legislative levels.
2. School Advocacy Program: To expand and coordinate the delivery of services and linkages between schools and community agencies.
3. Welfare Advocacy Program: To ensure access to welfare benefits by qualified pregnant and parenting teens.
4. Housing Study: To assess the housing needs of teen parent families in metropolitan Boston, to examine the range and limitations of existing resources and to document local and national model housing programs for this population.
5. Teen Parent Family Support Program: A national research demonstration program designed to assess the impact of providing vocational training or employment to first time teen mothers on their ability to remain in school.
6. Community Education Program: Designed to facilitate an in-service education and communication system for member agencies and other agencies and individuals concerned with the teenage pregnancy issue.

The Office for Children (OFC)

The Office for Children, through the Councils for Children and Community Development, works with networks and coalitions at the local level on issues relating to pregnant and parenting teenagers. Frequently, the chairperson of a local task force is a representative of the local Council. The Office for Children, through Help for Children, provides Information and Referral services to community members, including pregnant and parenting teenagers. At the local level, OFC helps teens find needed services and provides them with appropriate information about community programs.

OFC publishes, among other reports, a summary of the needs assessments of children throughout the state. The Needs Assessments are performed by Councils for Children to assist them in documenting the need for children's services. Councils may conduct general needs assessments, or focus on the specific need. The Councils utilize many data sources to gather and assess information. Basic needs areas are around the issues of food, clothing, day care, shelter, health care, mental health and other critical areas of need. A great need is in the area of day care - more funding was essential for subsidized day care services, both center-based and family day care. Thirteen councils identified day care as a priority service needed: Brockton, Berkshire, East Boston and Charlestown, Greater Lowell, Cape Cod and the Islands, Heritage, Plymouth, Northampton, and Worcester County. Other findings determined as needs by local Councils relating to pregnant and parenting teenagers are:

1. Transportation identified in Cape Cod and the Islands and Plymouth for teens with young children.

2. Adolescent mental health services were needed by many teens in several Council areas. Alternative living situations were also greatly needed for adolescents.

3. Drug and alcohol services were a strong need, along with parent training programs.

4. The Plymouth Council focused on the needs of pregnant and parenting teens, and found that OB/GYN and pediatric practices seldom refer pregnant and parenting teens to existing provider agencies offering appropriate services to this population.

5. Several Councils cited child abuse and neglect as a critical need area for the provision of services.

6. Preventive education programs that address parenting skills such as child growth and development, effective parenting, family planning and utilization of community resources are needed by adolescents.

7. The need for reduced fragmentation and more coordination and cooperation among service providers and agencies was stated by Councils across the state.

The Office for Children is an agency of the Executive Office of Human Services, and maintains 45 field offices in local communities. The Office is

involved in developing standards and licensure proceedings for all day care centers, group homes, family day care homes and foster care placement agencies.

The Office analyzes and evaluates budget requests for services to children, published in the yearly, The Children's Budget. The Office for Children also maintains Interdepartmental Teams statewide to help in the resolution of the most difficult children's cases. The Advocacy Unit coordinates the advocacy efforts of the citizen networks, and works to assure the sound and coordinated development of all services to children, and to assure parents a decisive role in the planning, operation and evaluation of programs which aid families in the care of children.

The Office for Children Councils for Children and Community Development staff played key roles in securing funding from EOHS for fourteen community-based coalitions organized to prevent teen pregnancy. According to the OFC newsletter from the fall of 1987, Local Councils and CD staff frequently play an important role in organizing local coalitions. OFC has set up a statewide network to help communities organize coordinated responses to the problems facing adolescents in the Commonwealth. The following

Area Councils and HELP FOR CHILDREN:

Region I:	Regional Office	413-568-9241	Region II:	Regional Office	791-3136
	Berkshire	413-499-4492		Blackstone Valley	473-3291
	Franklin/Hampshire	413-584-7970		Greater Worcester	791-3136
	Holyoke/Chicopee	413-538-9033		North Central	534-0280
	Springfield	413-736-0321		North Worcester	632-9179
	Westfield	413-568-3341		South Central	765-9175
		562-5014			
Region III:	Regional Office	727-4137	Region IVA:	Regional Office	891-0530
		535-6700			727-1429
	Cape Ann	927-5446		Cambridge/	623-5096
		468-3639		Somerville	
	Eastern Middlesex	245-5267		Concord	264-0314
	Heritage	745-9090		Greater Lowell	459-2566
	Greater Lawrence	685-0262		Waltham/Belmont/	891-8558
	Greater Lynn	581-7677		Watertown	
	Haverhill/	346-9617		Mystic Valley	729-4350
	Newburyport				
	Tri-City	389-5424			
Region IVB:	Regional Office	727-2532	Region V:	Regional Office	947-1231
	Coastline/South	849-1882		Attleboro/	226-2336
	Shore			Taunton	727-8948
	Greater Marlboro	481-3476		Brockton	727-8363
	South Middlesex	875-5264		Cape Cod	771-2151
	South Norfolk	762-0717		Fall River	727-7723
	West Suburban	965-9810		New Bedford	997-4531
				Plymouth	746-5101
Region VI:	Regional Office	727-8898			
		727-3298			
	Boston Southern	727-2468			
	Lower Roxbury	427-0606			
	Capitol	889-4660			
	Chelsea/Revere/Winthrop	889-4660			
	Bos-Line	738-4518			
	Bayside	288-6600			

Boston Student Human Services Collaborative

The Boston Student Human Services Collaborative was established in 1983 to bring public and private human services agencies and the Boston Public Schools together in a unique joint effort to address the human service needs of students.

According to a brochure issued by the Collaborative, the goals are:

* To reduce unmet social, physical and emotional needs of students and the associated or resulting school dysfunction.

* To alter the relationship within and between schools and human services agencies to maximize effective collaboration.

* To support the learning process and contribute to improved academic achievement and school climate.

The collaborative links individual member schools with health and social services agencies to create school-based human service Collaboratives. The Collaborative is a voluntary association between the Public Schools in Boston and public and private human services agencies. It is administered by an independent Board of Directors consisting of key decision-makers from the Boston Public Schools, state and city agencies, private agencies and parent and student groups.

While the Collaborative is not itself a funding source, it strives to increase the level of funds available. The Collaborative focuses on the development of programs in the following priority service areas:

1. Elementary School Level Prevention/Early Intervention Services

2. Substance Abuse Prevention/Intervention Services: Middle and High Schools

3. Comprehensive School-Based Health Programs: Middle and High Schools

4. Services for Pregnant and Parenting Students: Middle and High Schools

5. Special Initiatives: All Levels

Collaborative Schools from 1983 to 1986 are Boston Prep. School, Boston Technical High, Dorchester High, English High, Madison Park High, South Boston High, Curley Middle, Irving Middle, Rogers Middle, Timilty Middle, Cleveland, Henry Grew Elementary, Higginson Elementary, Tobin Elementary, Trotter Elementary.

The Collaborative has been supported by grants from Hyams Trust, The Boston Foundation, Riley Foundation and in-kind contributions from the Boston Public Schools.

The Chairperson of the Board of Directors is Hubie Jones, Dean of Boston University School of Social Work.

The Boston School Health Project was designed by two of BSHSC committees as part of a year long feasibility study. The committees include representatives from public health, education, medicine, parents and other community and human service groups.

The proposal is to deliver a wide range of health services to students in up to four secondary schools, including middle and high schools. Health services would be delivered at school sites by health teams from local hospitals or health centers.

Boston Foundation

Under Director Anna Faith Jones, a distinct program has been developed to renew the attack on poverty in Boston. The program is called the Poverty Impact Program, a special grantmaking program that is conducted in addition to the Foundation's other programs. The Poverty Impact Program is limited to Boston, whereas other activities of the Foundation extend to metropolitan Boston. The program will fund programmatic costs, and focuses on the poor. The program will support operating expenses of critical pilot programs and will fund projects for up to five years. Multi-year grants will be encouraged, and initiatives that are particularly deserving and large in scope will be eligible for grants as large as $100,000-$250,000. The Poverty Impact Program will fund small technical assistance grants for the development of proposals for large programs.

After examining the underlying causes of poverty in Boston and the specific needs of agencies and people, the Poverty Impact Program was developed. Under this program, the Foundation will seek to "mobilize resources, build alliances, and spur new activity on behalf of the poor."

The Foundation has allocated $10 million, or $2 million each year for 5 years, for the Poverty Impact Program. The Program will focus on the neighborhoods with the greatest need within the City of Boston, and "will respond particularly to the plight of women and children, and to the changing composition and struggle of urban families." Four primary areas of interest will be emphasized:

1. Maternal and Infant Health Care
2. Teenage Pregnancy
3. Employment and Training
4. Urban Parks and Public Spaces

"The Foundation is eager to participate in joint funding arrangements with foundations, corporations, and government agencies. It is requesting concept papers and proposals from non-profit agencies with ideas for large-scale, innovative programs that address the four interest areas:"

With regard to teenage pregnancy, the Foundation believes that interventions are imperative in both the preventive and service areas, and that activities could cluster around a range of activities:

the development of school-based programs and child care centers
organization of group homes and special housing arrangements
linkage of teen mothers to employment training and mentoring opportunities
preventive and service outreach programs from community-based churches and civic organizations
the development of a citywide preventive policy

In April, 1986, the Boston Foundation awarded a grant of $75,000 to the Roxbury Comprehensive Community Health Center and the Planned Parenthood League of Massachusetts for a program to help prevent teenage pregnancy. The grant was used to establish a Teen Pregnancy Prevention Initiative center in Roxbury. The program will offer health care, counseling and sex education along with a life options approach designed to make teens more aware of alternatives to early pregnancy. In addition to offering medical and family planning programs, the new program will offer job training and placement, academic tutoring, and GED preparation.

Healthy Start

Over 660,000 Massachusetts residents are without health insurance, and thousands more have inadequate coverage, according to the Health Care for All Coalition, a Boston group having over 50 organizations represented in the campaign. In Massachusetts, 32%, or 190,000 of the uninsured are children under age 19, with thousands more having serious medical problems that private insurance does not cover fully.

The Healthy Start Program was begun in December, 1985, as an effort to reverse the trends of increasing infant mortality, low birthweight infants, and reduced access to prenatal care. Recommendations contained in the program stemmed from the Department of Public Health's Task Force on the Prevention of Low Birthweight and Infant Mortality. The Department of Public Health assumed responsibility for the operational aspects of Healthy Start. Through the initiatives of House Ways and Means Chairman, Richard Voke, the program was funded in the FY86 budget as a demonstration project for part of the year at a level of $6 million. The Department of Public Welfare and the Department of Public Health cooperate on Healthy Start, which provides maternity-related medical coverage to all pregnant women financially ineligible for Medicaid, but whose income meets the WIC program standards. These standards are $9,713 per year for one person households, and $13,043 for two persons per year. Services provided are:

comprehensive prenatal care, to include regional case management and nutrition counseling, social services, and home visiting for women who require additional services
prenatal laboratory and special tests
prenatal prescription drugs
hospital costs for mother
hospital costs, including physical examinations, for newborn
one postpartum visit for mother

General medical care of the mother not considered related to the pregnancy is not covered. Referrals to the Healthy Start program can be made directly or by phone through WIC and MIC clinics, as well as through local welfare and public health offices. Healthy Start will cover up to 14 prenatal care visits.

Initial eligibility requirements were as follows:

* all single and married pregnant women, including pregnant minors, provided they have no health insurance or health plan that covers prenatal care and/or delivery

* applicants and enrollees who do not meet the requirements of the Medical Assistance Programs

* enrollees income must be within 185% of the federal poverty level - this has been revised; the income of the pregnant woman's husband is included in determination of eligibility, but parental income is not included for minors

Within the first few months of the program, 7400 enrolled; over 1500 were referred to Medicaid, and 290 enrolled in Medicaid. The numbers who enrolled surpassed the amount expected, therefore actual costs exceeded funds projected. During this time, the physician rate for maternity care services more than doubled, from $508 to $1-27. The average cost for Healthy Start for one pregnant woman is $3400-3500. Initial cost projections for the program did not consider:

- C-section costs
- increase in global fee
- cost of prenatal care in a community health center
- laboratory, pregnancy-related tests and pharmacy costs
- high-risk pregnancy costs

Of the first 5200 Healthy Start participants, 19%, or 988, were teenagers, 19 years and younger. Of these 5200, 26%, or 1352, were minority women. In the first three months of operation, from December, 1985 to February, 1986, 28% of those who registered, did so in the first trimester of pregnancy. Between July, 1986 and September, 1986, 56% registered in the first trimester. The Department of Public Health issues statistical information on the first 5300 clients who enrolled:

Enrollment by Region

Boston	2339-45%
Southeast	1015-19%
Western	555-11%
Central	633-12%
Northeast	697-13%

Total=5239

Enrollees by Race

White	3696-74%
Black	764-15%
Asian	192- 4%
Other	341- 7%

Total=4993

Enrollees by Highest Grade Completed

<=9	787-16%
10-11	1008-20%
12	2158-44%
>12	961-20%

Total=4914

Enrollees by Ethnic Origin

Puerto Rican	271-8%
Other Hispanic	389-11%
Haitian	224-6%
Chinese	117-3%
Laotian	87-2%
Cambodian	12-1%
Vietnamese	11-1%
Other	2347-68%

Total=3458

Enrollees by Age

<=15	40- 1%
16-17	279- 5%
18-19	666-13%
20-24	1957-37%
25-34	1985-38%
35+	312- 6%

Total=5239

Approximately 4500 pregnant women were eligible for the program in FY87. In 1987, legislation was filed by State Representative Patricia G. Fiero, and other legislators, on behalf of the Healthy Start Coalition. The legislation requested income eligibility at 200% of the federal poverty guidelines - $11,000 for a one-person household, $14,800 for a family of two; provide medically necessary care to maintain health during pregnancy and delivery, postpartum and newborn care; require assistance to women in applying for Medicaid; clarify eligibility of certain pregnant and parenting minors for Medicaid; and require that regulations be established within six months of the bill's passage. A legislative package and budgetary initiative was proposed by House Ways and Means Chairman Richard Voke.

The 200% of poverty eligibility was passed, along with language for comprehensive services, one ambulatory pediatric visit. However, the language shifts hospital costs to the free care pool, a fact that is a concern to advocates and others. For FY88, $6,658,376 was appropriated. For FY89 House 1 proposes a 3.8% COLA plus $4.2M to cover: FY88 physician rate increases ($2.4M); anticipated rate increases in FY89 ($647,000); one ambulatory pediatric visit per case ($284,000); and $864,000 for a limited scope of general medical care during pregnancy.

The Healthy Start Coalition consists of members from the Boston Committee on Access to Health Care, the Alliance for Young Families, Mass. Law Reform Institute, Mass. Health Council, Inc. Mass. Disabilities Council, and other groups. The Coalition feels that there is a need for fair, equitable, and adequate prenatal care programs for poor and near-poor women, that is crucial for the prevention of serious consequences for mother and child. The Coalition believes that the program is critical to efforts in reducing infant mortality and low birthweight births. An aim is to increase outreach, particularly to teens, bilingual, and minority women. A goal is to expand the scope of the program to cover medically necessary care during pregnancy, and provide for support services, case management, transportation, counseling, and other services. Also, the Coalition is focusing on a major public education and media campaign, and to add at least one ambulatory visit. The Coalition seeks to make Healthy Start permanent and fully funded for all eligible women. For FY89, the Coalition is recommending a budget of $14 million to cover the full scope of allowable services based on a projected caseload of 6200 women, and has filed legislation to establish Healthy Start as an entitlement program.

Some aspects of Healthy Start has been incorporated into plans for universal health care in Massachusetts, and will come before the Legislature in early 1988.

Healthy Baby

Boston spends about $450,000 a year on Healthy Baby, and another $600,000 in city funds has been targeted for prenatal care through neighborhood health centers, and follow-up postnatal care for high-risk infants. Boston has nearly 1300 enrolled in the program who are at-risk for poor pregnancy outcomes. The program was begun in mid-1985, in response to a 32% increase in Boston's infant mortality rate between 1981 and 1982.

Massachusetts Adolescent Pregnancy and Parenting System: MAPPS, Dept. of Public Health

MAPPS is a standardized data collection system, administered by the Division of Family Health Services (DFHS) in the Mass. Department of Public Health. The monitoring system is designed to gather information on pregnant and parenting young women in Massachusetts, who participate in programs supported by the DFHS. As of March, 1987, the Division funded nine programs, located at twenty-six sites across the state, which serve over 2,000 adolescents each year, 18 years of age and younger who have not completed school.

MAPPS was initiated during the change from Title V to MCH Block Grant funding mechanisms. At that time three programs in Massachusetts funded by the federal Office of Adolescent Pregnancy Programs came under the administration of DFHS. MAPPS was designed by DFHS, with assistance from Dr. Deborah Klein Walker at the Harvard School of Public Health in order "to better understand this population and provide background information necessary to develop an improved service system for them throughout the Commonwealth."

The Massachusetts adolescent pregnant and parenting programs are funded through "contracts to hospitals, neighborhood health centers, family planning projects, Visiting Nurse Associations and social service agencies." Program models vary, but all offer a range of services and provide a continuum of care to the teen mother, her baby, and her family. All programs include health care, psychosocial services, liaisons to schools, alternative educational programs, home visiting and family planning. Each year the Division issues an annual report, prepared by Judith Gorbach, Department of Public Health.

The report issued in March, 1987, summarizes the services provided by the DFHS through 13 contracts for adolescent health care. Three agencies received funds for the Comprehensive Adolescent Health Program (CAHP) model, seven agencies for the Pregnant and Parenting Adolescent Program (PPAP) model and three agencies for both program models. Adolescent health contracts range from small programs consisting of one to three individuals providing health and social services in a town to contracts for coalitions in which many agencies offer coordinated services or where services are provided in multiple sites. "In order to finance comprehensive care composed of both health and social services, agencies must of necessity receive funding from more than one source. Therefore, the activities and services reported in this document are the result of more than one source of public and private funding."

Case management is provided with health, educational and psychosocial services coordinated and tailored to the individual client's needs. "Special efforts are made, through community contacts, for identifying the young woman early in her pregnancy, engaging her in the program and maintaining contact. Continuity of care is provided not only throughout her pregnancy, but well into the postpartum period." Group sessions are offered on prenatal care, childbirth and child development. Transportation and child care is usually arranged. Meal preparation may be incorporated into group sessions as "hands on" nutrition education.

All programs are encouraged to develop and adopt a teen-tot care model where the baby and mother are seen in concert, allowing pediatric care to be provided simultaneously with the mother receiving attention for her adolescent needs and support in her parenting skills. The aim is "to support as much prevention as possible through a combination of health care and educational programs."

The report states that while prenatal care is emphasized, with early entrance into care a priority, and there has been some improvement in early referrals, there are still many pregnant adolescents who enter the programs in their third

MAPPS

trimester or who are identified at the time of delivery having had no prenatal care. Coordination with other programs is emphasized and has resulted in 66% of the clients being registered in WIC and 17% accessing prenatal care through MIC sites.

The Pregnant and Parenting Adolescent Programs provide child development, parenting and life skill education, and support counseling for students who are attending specialized school-based programs designed for pregnant and parenting students. "The concentration of school-age mothers in one place, e.g. school, day care, or GED classes, has provided increased opportunities to run support groups with education and counseling sessions. These extra demands for individual and group counseling to encourage and support the consistent use of such services has strained the already filled case loads of the Pregnant and Parenting Adolescent Programs."

Since only a small portion of school-age parents are able, or willing, to attend these school-based programs, there has been a determined effort to respond to the Department of Welfare's Employment and Training RFP targeted for parenting teens. The PPAP programs worked in conjunction with other agencies in communities, to develop new program models to be supported jointly by DFHS and ET dollars.

Program workers have participated in local coalitions and task forces on infant mortality, prenatal care, and teenage pregnancy, in addition to providing direct services.

The MAPPS standardized forms for each program are completed at intake during the perinatal period, at birth, and at six, twelve, and eighteen and twenty-four months post delivery. Information is collected on each client's demographic, social, economic and educational background, as well as health and social services received.

According to the annual report, "the study is designed to provide data on short and long-term outcomes of school-aged pregnancy and to document the relationships among biosocial factors, perinatal services received, birth outcomes, and developmental outcomes of mothers and children in the two years after delivery. Short term outcomes such as perinatal morbidity and mortality, school attendance, marriage, living arrangements and adoption, will be reviewed by level of prenatal care, socioeconomic and demographic data, and program components received." The longterm outcomes of interest for school-age mothers are school completion, job training, economic independence, and repeat pregnancies and births.

The report issued in March, 1987, covers data from October, 1982 through October, 1986. For FY86, DFHS renewed 12 Adolescent Health Services contracts, added new programs in Holyoke, and increased funding for prenatal care services in Haverhill. The Comprehensive Adolescent Health Programs, CAHPS, emphasizes primary prevention targeted to at-risk populations, and PPAP programs deliver services to childbearing teens, babies, partners, and families.

Statistical Data

In 13 adolescent programs, 51,555 clinic visits were held, serving 33,653 individuals.

Health Care Services:

* 31,352 medical examinations, including 630 school health physicals; 2,274 infant and toddler examinations; 17,347 prenatal and postnatal examinations

* 83,017 social service counseling sessions
* 10,366 nutrition sessions
* 14,499 family planning visits
* 5,604 pregnancy tests
* 12,869 home visits
* 4,038 telephone hotline calls

Educational Programs:

* 42,798 teenagers including 6,382 pregnant and parenting teens
* 338 teen groups met
* 5,859 parents
* 8,221 professionals

119 public and private schools received educational programs

2,507 agencies were contacted in order to facilitate coordination and provide referrals for adolescent clients

93 cities and towns were served

The following charts are taken from the Annual Report of the Division of Family Health Services.

COMPREHENSIVE ADOLESCENT HEALTH PROGRAMS

23,773 individuals were seen in 34,297 clinic visits by the 6 programs.

85.7% of the adolescent clients were female.
57.4% of clients served were white, 27.5% black, 13.3% Hispanic and 1.8% other ethnic groups.

44.7% of the clients were less than 18 years old.
11.8% were under 15 years, 32.9% were aged 15-17, 18.0 age 18-19, and 27.3% were older.

606 youths were under the auspices of DYS or, the courts or were CHINS referrals.

35% used Medicaid for reimbursement
30% were self pay (client or their family)
35% had some form of insurance coverage.

PREGNANT AND PARENTING ADOLESCENT PROGRAMS

There are 10 contracts for PPAPs. Services are delivered at 24 different sites; some of these are actually distinct programs under one contract. (See site listing attached).

7,606 adolescents were seen in addition to 2,274 infant and toddlers in 17,347 clinic visits.

6,027 pregnant and/or parenting women were seen and 1,579 male partners.

Of the female clients:

46% were white, 31% black, 22% Hispanic, and 1% were of other ethnic backgrounds.

6% were 14 years old or younger, 49% between 15-17 years, 10% 18-19 years, and 35% were older.

68% were receiving Medicaid at the time of delivery.

Summary by Federal and State Funding

	State	Federal	Total
CAHP	$256,208	$182,464	$438,672
PPAP	437,748	559,771	997,519
	$693,956	$742,235	$1,436,191

Adolescent Health, 3/87

The report gives a breakdown of service programs by region, and by the types of services provided at sites within the region. The following are the names of service agencies, by region, with the total allocation of funds for that region. The report lists the types of services provided, and the numbers of clients participating in those services.

Western Region: Total: $246,619
Contracts: 3 PPAP: County Adolescent Network of the Berkshires
Pittsfield: VNA; PASS Office
North Adams:PASS Office

Family Planning Council of Western Ma.
Springfield Services for Adolescent Family Enhancement - S.A.F.E.
Holyoke Chicopee Area Health Resources
Holyoke: Community Adolescent Resource and Education Center-CARE

Central Region: Total: $314,431
Contracts: 2 CAHP $159,675
1 PPAP $154,666
CAHP: Health Information Referral Services, Marlboro
Health Awareness Services of Central Ma., Worcester and Webster
PPAP: Health Awareness Services of Central Ma., ACCESS, Worcester

Southeast Region:Total: $97,754
Contracts: 1 PPAP: Health Care of Southeastern Massachusetts
Falmouth Early Childbearirg Program
Taunton Early Childbearing Program

Northeast Region: Total: $182,240
Contracts: 2 CAHP: $121,680
1 PPAP: $ 60,560
CAHP: St. John's Hospital, Lowell
Healthworks: Lowell, Lawrence, Lynn
PPAP: Healthworks: Haverhill
North Shore VNA
Hale Hospital Prenatal Clinic

Greater Boston Area: Total: $595,237
Contracts: 2 CAHP: $157,317
4 PPAP: $437,920
CAHP: Martha Eliot Health Center
Trustees of Health and Hospitals
Adolescent Center - BCH
Dorchester House
Harvard St. Health Center
Little House

PPAP: Brigham and Women's Hospital -Adolescent Reproductive Health Service, B and W Hospital; Brookside Neighborhood H.C.; Crittenton Hastings House; Southern Jamaica Plain H.C.; Children's Hospital Young Parent Program; St. Margaret's Hospital; Trustees of Health and Hospitals; Dorchester House; Harvard St. H.C.

The following chart gives Adolescent Health Services by regional summary of services provided. Programs are described in the following directory, by Health Service Area, and are designated as part of the MAPPS studies.

MASSACHUSETTS ADOLESCENT PREGNANT AND PARENTING SYSTEM

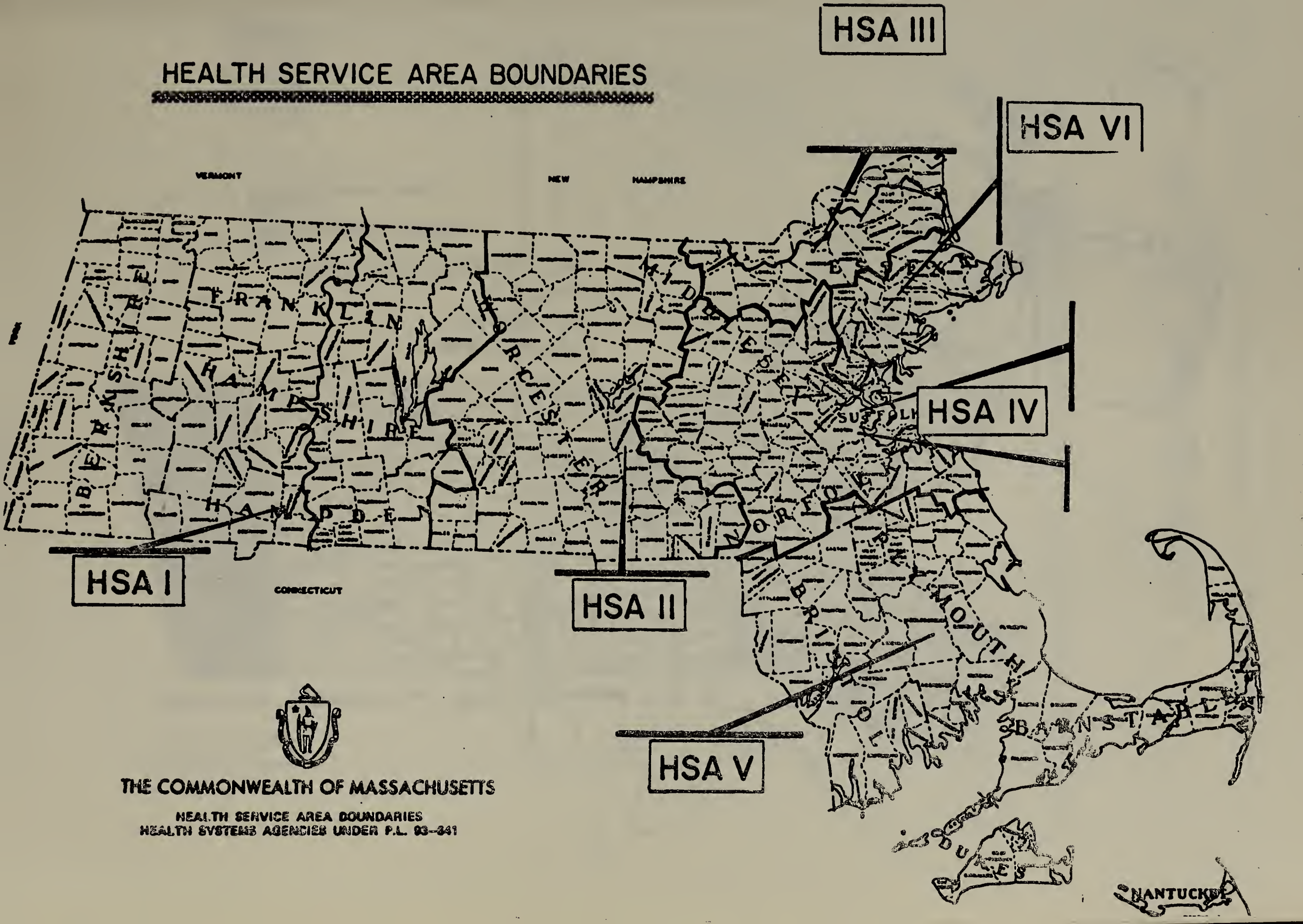
SOCIODEMOGRAPHIC DESCRIPTION OF CLIENTS AT INTAKE

OCTOBER 1982 THROUGH SEPTEMBER 1986

		Percent	Number
Client Status:	pregnant	87.4	2,948
	mother	12.6	425
Age:	<15	7.5	253
	15	15.5	524
	16	24.6	829
	17	34.5	1,165
	18	17.9	603
Ethnicity:	White	48.4	1,645
	Black	30.4	1,027
	Hispanic	19.3	650
	Other	1.5	52
Marital Status:	Single	92.5	3,120
	Married	6.9	234
	Separated or divorced	6.6	20
Contraceptive Use:	Always	6.8	188
	Sometimes	30.3	837
	Never	62.9	1,736
Number of Previous Pregnancies:	0	79.1	2,600
	1 +	20.9	686
Living Arrangements:	Alone or with partner	14.0	473
	client's mother (single mother)	41.9	1,414
	2 parent household	20.2	682
	Other	23.8	803
Educational Status:	in school	57.9	1,950
	dropped out of school	40.1	1,351
	graduated and received GED	2.0	68

All charts and information excerpted from Annual Report of the Division of Family Services, Dept. of Public Health, MAPPS; Report gives program descriptions, outcome data, and site-specific information.

HEALTH SERVICE AREA BOUNDARIES

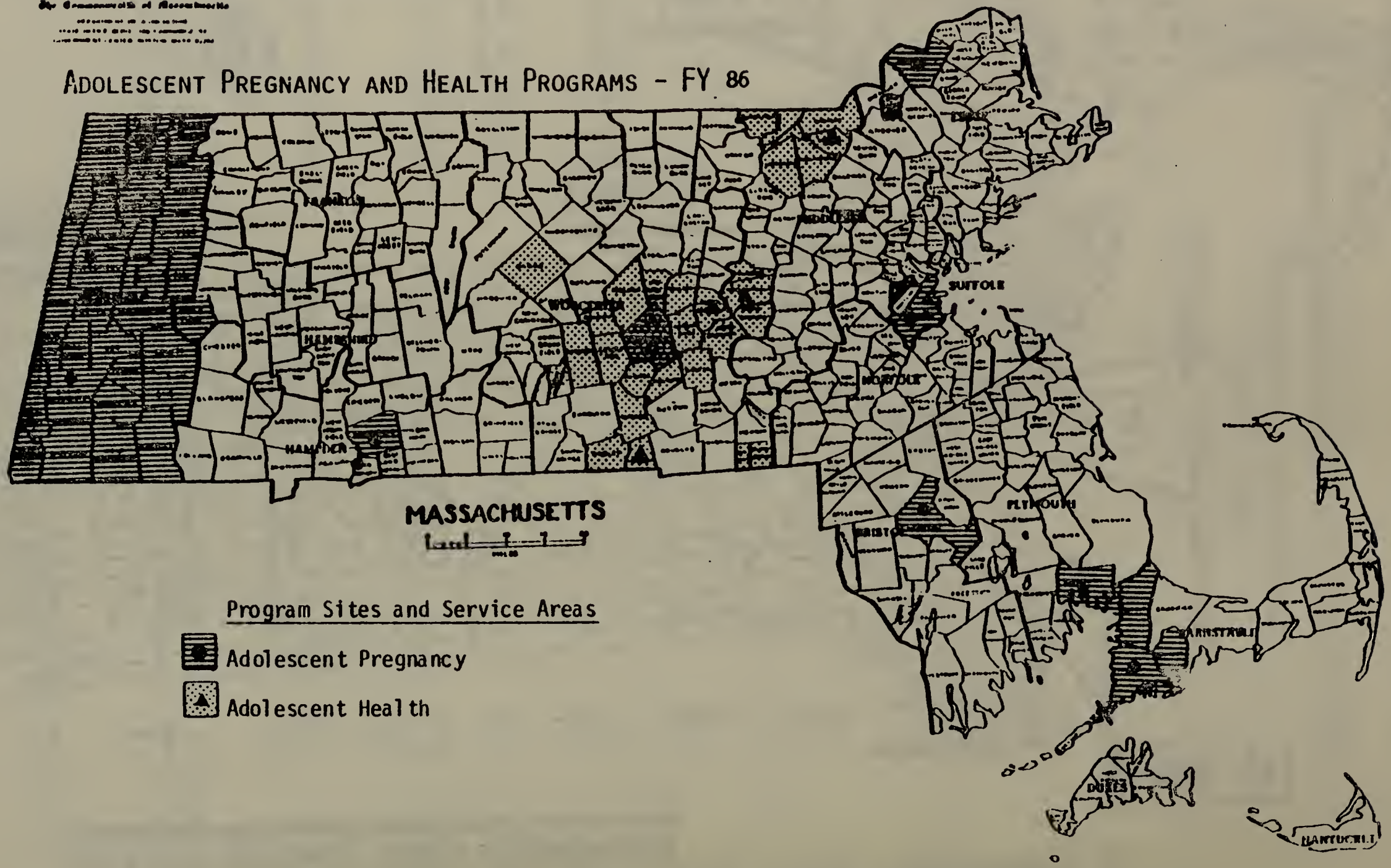


THE COMMONWEALTH OF MASSACHUSETTS

HEALTH SERVICE AREA BOUNDARIES
HEALTH SYSTEMS AGENCIES UNDER P.L. 93-641

The Commonwealth of Massachusetts

Adolescent Pregnancy and Health Programs - FY 86

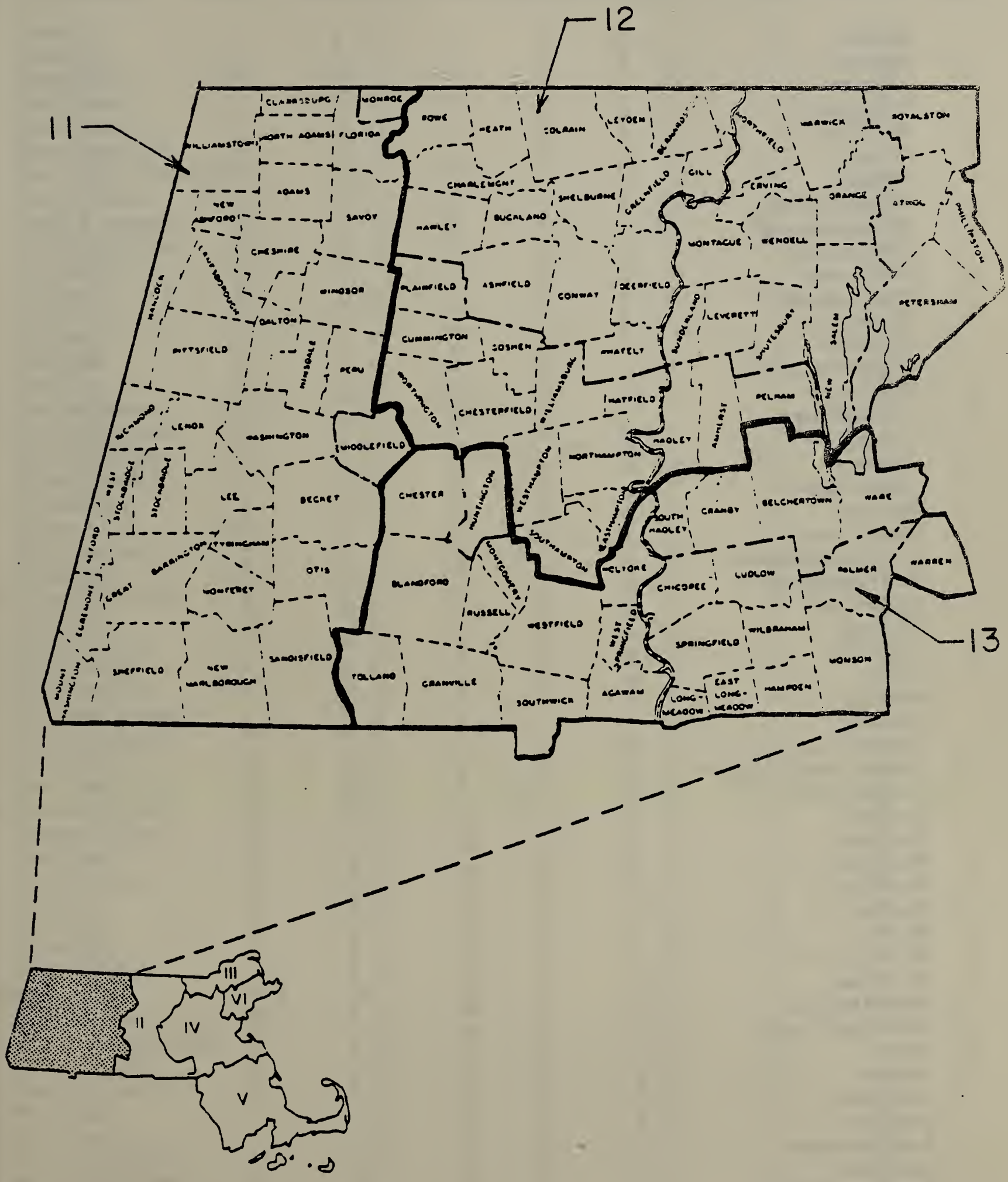


Program Sites and Service Areas

- Adolescent Pregnancy
- Adolescent Health

HEALTH SERVICE AREA MAPS

HEALTH SERVICE AREA I



Massachusetts Cities and Towns: Teenage Births, 1984-1985

Health Service Area 1: Total Teen Births: 1984-1249 1985-1188

City/Town	#Teen Births School-Age, 12-17 1984	1985	Older, 18-19 1984	1985	Total Teen Births 1984	1985
Adams	5	1	7	8	12	9
Agawam	8	7	15	14	23	21
Alford	0	0	0	0	0	0
Amherst	4	1	4	6	8	7
Ashfield	0	0	1	2	1	2
Athol	3	8	17	19	20	27
Becket	0	0	1	1	1	1
Belchertown	1	2	1	7	2	9
Bernardston	0	0	0	0	0	0
Blandford	0	0	0	0	0	0
Buckland	0	0	1	2	1	2
Charlemont	0	1	2	0	2	1
Cheshire	2	0	1	4	3	4
Chester	1	0	1	1	2	1
Chesterfield	0	1	0	0	0	1
Chicopee	32	22	40	40	72	62
Clarksburg	1	2	1	0	2	2
Colrain	0	0	1	6	1	6
Conway	0	0	0	0	0	0
Cummington	0	0	0	0	0	0
Dalton	0	3	5	3	5	6
Deerfield	1	2	1	0	2	2
E. Longmeadow	0	2	2	1	2	3
Easthampton	6	4	13	14	19	18
Egremont	0	0	0	0	0	0
Erving	0	1	0	0	0	1
Florida	0	0	0	0	0	1
Gill	0	0	0	2	0	2
Goshen	0	0	0	1	0	1
Granby	3	0	4	2	7	2
Granville	0	0	0	0	0	0
Great Barrington	2	1	4	2	6	3
Greenfield	4	8	16	14	20	22
Hadley	0	0	1	0	1	0
Hampden	3	0	2	0	5	0
Hancock	0	0	1	0	1	0
Hatfield	0	0	0	0	0	0
Hawley	0	0	0	0	0	0
Heath	1	0	0	1	1	1
Hinsdale	1	0	3	1	4	1
Holyoke	63	74	78	114	141	188
Huntington	0	0	3	2	3	2
Lanesborough	0	2	1	3	1	5
Lee	0	1	1	1	1	2
Lenox	2	0	3	3	5	3
Leverett	0	0	0	1	0	1
Leyden	0	0	1	1	1	1
Longmeadow	1	0	1	2	2	2
Ludlow	5	1	6	8	11	9
Middlefield	0	0	1	0	1	0

Massachusetts Cities and Towns: Teenage Births, 1984-1985

City/Town	#Teen Births School Age, 12-17 1984	1985	Older, 18-19 1984	1985	Total Teen Births 1984	1985
Monroe	0	0	0	0	0	0
Monson	2	0	3	6	5	6
Montague	5	5	10	7	15	12
Monterey	0	1	0	0	0	1
Montgomery	0	0	0	0	0	0
New Ashford	0	0	0	0	0	0
New Marlborough	0	0	1	0	1	0
New Salem	1	0	0	0	1	0
North Adams	6	10	33	26	39	36
Northampton	8	5	7	13	15	18
Northfield	0	0	2	1	2	1
Orange	8	7	6	15	14	22
Otis	0	0	0	1	0	1
Palmer	5	4	7	16	12	20
Pelham	1	0	1	0	2	0
Peru	0	0	0	1	0	1
Petersham	0	0	1	0	1	0
Phillipston	1	0	0	1	1	1
Pittsfield	25	20	53	49	78	69
Plainfield	0	0	0	0	0	0
Richmond	0	0	1	1	1	1
Rowe	0	0	0	0	0	0
Royalston	1	0	2	0	3	0
Russell	0	0	1	3	1	3
Sandisfield	0	0	0	1	0	1
Savoy	0	0	1	0	1	0
Sheffield	2	0	0	3	2	3
Shelburne	0	0	1	2	1	2
Shutesbury	0	0	0	1	0	1
South Hadley	1		11		12	
Southampton	3	3	1	2	4	5
Southwick	7	5	4	12	11	17
Springfield	198	175	306	243	504	418
Stockbridge	0	0	0	1	0	1
Sunderland	1	0	3	1	4	1
Tolland	0	0	0	0	0	0
Tyringham	0	1	1	0	1	1
Ware	4	8	17	10	21	18
Warren	2	2	10	4	12	6
Warwick	1	0	0	0	1	0
Washington	0	0	0	0	0	0
Wendell	1	0	1	0	2	0
W. Springfield	7	10	10	20	17	30
W. Stockbridge	0	0	0	0	0	0
Westfield	15	11	36	28	51	39
Westhampton	0	0	0	1	0	1
Whately	0	0	0	0	0	0
Wilbraham	3	4	5	7	8	11
Williamsburg	0	0	1	0	1	0
Williamstown	2	0	3	1	5	1
Windsor	0	0	1	1	1	1
Worthington	0	0	0	0	0	0

HEALTH SERVICES: MASSACHUSETTS — HEALTH SERVICE AREA I

Athol

1. Catholic Charities, Family and + — Contact Person: Charles Bevacqua
Children's Services — 617-343-7118
12 Riverbend Street
Athol, Ma. 01331

Services: Pregnancy testing and counseling; crisis intervention; family reconciliation; arrangement for prenatal services; maternity home services; foster home care; adoption services; parenting assistance; material assistance; post abortion counseling; individual, marital, and family counseling; prenatal group services for young mothers/fathers-to-be and their parents; postnatal group services to support the decisions adolescent parents make ; educational services including parent education, parenting skills, prevention of child abuse and neglect, vocational and career counseling, and sexuality and assertiveness training.
Funding Sources:

Number of Teenagers Serviced Each Year:

2. Community Health Service + — Contact Person: Cynthia Caldwell
Division of Athol Memorial Hospital — 617-249-5366
423 Main Street
Athol, Ma. 01331

Services: Provides preventive and therapeutic health care skills on an intermittent basis in home and community settings; skilled nursing; physical therapy; social work; home/health aide; contracts with Athol and Orange Boards of Health to provide preventive health programs; health screening; maternal/child health care; school nursing; home visits; referrals to WIC, DSS, etc.
Funding Sources: Since there is limited reimbursement under Board of Health Contracts for pregnant and parenting teens, CHS is not able to provide as many services to this population as they would like; 3rd party insurance

Number of Teenagers Serviced Each Year: Visits made to 336 pregnant women a year; visits made to 408 parenting women a year.

3. Human Resource Center for Rural Communities +Contact Person: John Szivos
100 Main Street — 617-249-9926
Athol, Ma. 01331

Services: Provides health, mental health, and nutrition education services; Child Health Program; Women, Infants, and Children Program (WIC); Outpatient Mental Health; Family Treatment Program; Consultants to Athol-Royalston School District Teen Pregnancy Program; counseling/therapy to teen parents and pregnant teens to develop life goals and directions; family or group therapy when clinically appropriate; case management; workshops in decision-making, teen pregnancy and prevention, with teens and parents.
Funding Sources:

+ Indicates member of Franklin-Athol Teen Pregnancy/Parenting Network

HEALTH SERVICES: MASSACHUSETTS HEALTH SERVICE AREA I

Number of Teenagers Serviced Each Year:

4. People's Bridge Action+
465 Main Street
Athol, Ma. 01331
Contact Person: Susan Bussiere
617-249-2248

Services: Outreach counseling services to pregnant and parenting teenagers; focus on dysfunctional, multi-problem adolescents; therapy or counseling in homes; advocacy; services to teens experiencing various types of difficulty-emotional, medical, academic, legal, poverty, etc.; self-help groups; case management; treatment planning; follow-up services; family life skills and home management.
Funding Sources: DSS/DMH, with a United Way Contribution
Number of Teenagers Serviced Each Year: Pregnant: 27-33 Parents: 36-46 (Walk-ins included)

5. Family Health Program
521 Main Street +
Athol, Ma. 01331
Contact Person: Bev Larkin, RN
617-249-2647

Services: Prenatal services and care; health education; pediatric services.
Funding Sources: DPH; MIC/C&Y.
Number of Teenagers Serviced Each Year: Program just beginning.

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6. Florence
Northampton Visiting Nursing Association
92 Main Street
Florence, Ma. 01060
Contact Person:
617-584-1060

Services: Evaluation, assessment; health teaching; nursing intervention; physical, occupational and medical social work intervention when ordered by a physician; well-child clinic; individual counseling.
Funding Sources: Private; Medicaid; insurance; United Way.
Numbers of Teenagers Serviced Each Year: Pregnant: 2, at times more; Parents: 10-20.

7. Great Barrington
Children's Health Program
P.O. Box 30
284 Main St.
Great Barrington, Ma. 01201
Contact Person: Clare Stomper
413-528-9311

Services: Counseling, Parenting sessions, individual and group counseling; community outreach; parents trained as volunteer home visitors; health care services.
Funding Sources: DPH/DFHS Early Intervention Contracts; town and county funding; patient fees; Medicaid reimbursement; private fund-raising; foundation grants.
Numbers of Teenagers Serviced Each Year: Parents: 3-4.

HEALTH SERVICES: MASSACHUSETTS — HEALTH SERVICE AREA I

8. Pregnant, Adolescent Support System — Contact Person:
VNA Great Barrington — 413-528-0130
55 Castle Street
Great Barrington, Ma. 02130

Services: See #18

Funding Sources:
Number of Teenagers Serviced Each Year:

Greenfield:

9. Family Planning Council of Western Mass. + — Contact Person: Barbara Brown
80 Sanderson Street — 413-773-5403
Greenfield, Ma. 01301
also office in Athol: 312 Main St., Rear, Athol, 01331

Services: Provides counseling, gynecological care, contraceptives, and education to individuals and community groups; of current caseload in Franklin County, 27% are adolescents; reports on file with Task Force state location and type of services and educational/outreach programs provided; family planning services; family life education in schools; WIC; primary health care; comprehensive assurance program.
Funding Sources: DPH; DHHS Grant; WIC

Number of Teenagers Serviced Each Year:

10. Franklin Community Action Corporation + — Contact Person: Anna Morrison
Drop-In Center — 413-774-7027
86 Washington Street
Greenfield, Ma. 01301

Services: Parenting support program; parent nurturing; teen parents' support/education group; short-term respite child care; transportation; educational and vocational growth; safety and nutrition; child development.
Funding Sources: DSS,

Number of Teenagers Serviced Each Year:

11. Franklin Medical Center + — Contact Person: Susan Myers
Social Work Department — 413-772-0211
164 High Street
Greenfield, Ma. 01301

Services: Identify all pregnant/parenting teens admitted to hospital; intervene with high risk teens; services to parenting teens whose children are admitted to pediatric unit; coordinate discharge planning; plan to coordinate childbirth classes and education; plan to provide psychosocial assessments, short-term support counseling, crisis intervention; referral services
Funding Sources:

Number of Teenagers Serviced Each Year:

HEALTH SERVICES; MASSACHUSETTS — HEALTH SERVICE AREA 1

12. Visiting Nurse and Health Services in Franklin County +
50 Miles St.
Greenfield, Ma. 01301
Contact Person: Dorothy Garvin
413-774-2302

Services: Home health services; therapeutic care; intervention; counseling and guidance; nursing, physical, speech and occupational therapies; home health aide, homemaker services; WIC; Maternal and Child Health Program-MIC; services to surrounding towns and cities; plan prenatal and parenting groups.
Funding Sources: United Way, MIC, WIC, Medicaid; other insurances
Number of Teenagers Serviced Each Year:

13. Massachusetts Society for the Prevention of Cruelty to Children (MSPCC) +
479 Main Street
Greenfield, Ma. 01301
Contact Person: Judy DeWitt
413-544-7174

Services: Family Counseling, support in decisions to place children for adoption, or becoming functioning parents; parenting skills training; prevention of abuse/neglect; Parent Aide-household management, childrearing skills; nutrition, budgeting, housing, discipline, realistic expectations of children; volunteer program, under direction of social worker-perform direct services such as transportation, respite care, volunteer parent aides; proposed expansion of counseling services, volunteer program, Administrative Clinical Supervisor; plan to implement evaluation component of programs.
Funding Sources: Private; contracts with Partnership Donated Funds Program.
Number of Teenagers Serviced Each Year:

14. Franklin County DIAL/SELF +
P.O. Box 184
Greenfield, Ma. 01302
Contact Person:
413-774-7054

Services: Transition to Independent Living Program; advocacy; counseling; education; support; semi-supervised residence; CHINS adolescent outreach and counseling; parenting sessions; parental involvement; individual and group sessions.
Funding Sources: DSS
Number of Teenagers Serviced Each Year: Total-30-35; Pregnant: 1-2; Parents: 1-2

15. Holyoke Teen Clinic, Inc. High School
500 Beech St.
Holyoke, Ma. 01040
(also discussed under school-based programs)
Contact Person: Betty Bradley
413-534-2020x19

Services: School-based program; personal counseling; advocacy; network with community agencies; members of Holyoke System for Pregnant and Parenting Teens; comprehensive primary health care and counseling; range of medical services-physical exams, sports physicals, treatment for illness, some lab tests and immunizations; counseling on personal hygiene, sexuality, alcohol and drug abuse, family and relationship issues; medical and counseling services for pregnant and parenting teenagers; prenatal services received from Providence Hospital Pre-Natal Clinic through referral; family planning counseling; Holyoke/Chicopee Area Mental Health services provided to students on alcohol abuse, anger, depression, relationship and family problems; work with Holyoke Pediatric Assoc., Holyoke Health Center, VNA, Pre-Natal Clinic, Holyoke Board of Health, Family Planning. Member of Infant Mortality Task Force, CHANS-Holyoke Adolescent Needs and Services.
Funding Sources: Dept. Public Welfare, 3rd party; billing done by individual agencies
Number of Teenagers Serviced Each Year: Pregnant: 40-50 Parents: 25-30
Total Encounters for 1986: 2650

HEALTH SERVICES: MASSACHUSETTS HEALTH SERVICE AREA 1

16. Holyoke-Chicopee Area Health Resources, Inc. Contact Person: Jane Sanders
Holyoke Hospital; CARE Center Executive Director
20 Hospital Drive 413-534-2566
Holyoke, Ma. 01040
MAPPS-PPAP

Services: Along with Teen Clinic in Holyoke High School, and Elm Street Prenatal Clinic, CARE Center belongs to Holyoke Infant Mortality Task Force - model-three component approach to adolescent pregnancy; parenting, decision-making and life skills; comprehensive program; primary goal is to enable pregnant and parenting teenagers to remain in school; WIC; VNA-nursing care; MSPCC - parenting education: Holyoke Hospital - individual and family therapy; Holyoke High School - tutoring; Family Planning - counseling, contraceptives and medical testing; Junior League-resource library and volunteers; Brightside Children's Center - social worker, nurse.
Funding Sources: DPH; In-kind contributions
Number of Teenagers Serviced Each Year:

17. Holyoke Visiting Nurses Association Contact Person:
238 Linden Street 413-534-5691
Holyoke, Ma. 01040

Services: Nursing and health care

18. Providence Hospital Adolescent Program Contact Person: Elena Izikoff
1233 Main Street (see #34) Patrick McCarthy
Holyoke, Ma. 01040 413-788-0896

Services: Residential program for alcohol and/or other substance abusing adolescents; psychological, educational and vocational testing; medical examination; individual and group therapy; educational program; follow-up counseling for outpatient care.
Funding Sources: Sliding Scale Fee

North Adams

19. Pregnant Adolescent Support System PASS Contact Person: Maggie Bittman
Haskins Community Center 413-664-6104
210 State Street
North Adams, Ma. 01247
MAPPS-PPAP
Services: Coordinate Services in order to affect healthy outcome for teenager and her baby; coordinate new programs as needed; community education; client manager for two years postpartum; network with community agencies and support systems; in school programs; coordinate parenting skills program with Early Identification; coordinate childbirth preparation classes with Cooperative Childbirth; teen fathers.
Funding Sources: DPH
Number of Teenagers Serviced Each Year: Pregnant: 28 Parents: 70

HEALTH SERVICES: MASSACHUSETTS — HEALTH SERVICE AREA 1

16. Holyoke-Chicopee Area Health Resources, Inc. — Contact Person: Jane Sanders, Executive Director, 413-534-2566
Holyoke Hospital; CARE Center
20 Hospital Drive
Holyoke, Ma. 01040
MAPPS-PPAP

Services: Along with Teen Clinic in Holyoke High School, and Elm Street Prenatal Clinic, CARE Center belongs to Holyoke Infant Mortality Task Force - model-three component approach to adolescent pregnancy; parenting, decision-making and life skills; comprehensive program; primary goal is to enable pregnant and parenting teenagers to remain in school; WIC; VNA-nursing care; MSPCC - parenting education: Holyoke Hospital - individual and family therapy; Holyoke High School - tutoring; Family Planning - counseling, contraceptives and medical testing; Junior League-resource library and volunteers; Brightside Children's Center - social worker, nurse.
Funding Sources: DPH; In-kind contributions
Number of Teenagers Serviced Each Year:

17. Holyoke Visiting Nurses Association — Contact Person: 413-534-5691
238 Linden Street
Holyoke, Ma. 01040

Services: Nursing and health care

18. Providence Hospital Adolescent Program — Contact Person: Elena Izikoff, Patrick McCarthy, 413-788-0896
1233 Main Street (see #34)
Holyoke, Ma. 01040

Services: Residential program for alcohol and/or other substance abusing adolescents; psychological, educational and vocational testing; medical examination; individual and group therapy; educational program; follow-up counseling for outpatient care.
Funding Sources: Sliding Scale Fee

North Adams

19. Pregnant Adolescent Support System PASS — Contact Person: Maggie Bittman, 413-664-6104
Haskins Community Center
210 State Street
North Adams, Ma. 01247
MAPPS-PPAP
Services: Coordinate Services in order to affect healthy outcome for teenager and her baby; coordinate new programs as needed; community education; client manager for two years postpartum; network with community agencies and support systems; in school programs; coordinate parenting skills program with Early Identification; coordinate childbirth preparation classes with Cooperative Childbirth; teen fathers.
Funding Sources: DPH
Number of Teenagers Serviced Each Year: Pregnant: 28 Parents: 70

Northampton

20. Children's Aid and Family Service
8 Trumbull Road
Northampton, Ma. 01060
Contact Person:
413-584-5690

Services: Counseling, community advocacy, childbirth education and preparation, pregnancy education, adoption counseling; outreach; individual counseling for parenting teens, advocacy; parenting education; Young Mothers Support Group; collaborative with Family Planning; LIFT for outreach family therapy; Sojourn for life skills training, day care, counseling, GED, and vocational counseling.
Funding Sources: United Way; Private Insurance; Fees; DSS contracts.
Number of Teenagers Serviced Each Year: Pregnant: 80 Parents: 110

21. Family Planning Council of Western Mass., Inc.
16 Center Street
Northampton, Ma. 01060
Contact Person: Ellen Story
Amy Aaron
413-586-2016

MAPPS-PPAP
Services: Comprehensive reproductive health care including medical and counseling services and referral; laboratory testing for all medical reasons; birth planning methods; OB-GYN examinations; VD screening; pregnancy testing; sponsor theatre group-"TEAM Players"; sexuality education.
Funding Sources: Client Fees; fundraising; Federal-Title X; State-Title XX, Title XIX, DPH.
Number of Teenagers Serviced Each Year: Pregnant: Not available; Parenting: 45 new patients in 1985, ages 15-20 yrs.; 138 patients of unknown parity.

22. Sojourn
142 Main Street
Northampton, Ma. 01060
Contact Person:
413-586-6807

Services: Short and long-term counseling; advocacy-aid with welfare, legal, and medical systems; provide life management and sexual abuse groups; tutoring and GED preparation classes; job planning and placement; short term day care and transportation.
Funding Sources: DSS, DMH, DPW, DYS, DPH, HHS, City of Northampton.
Number of Teenagers Serviced Each Year: Pregnant: 8 Parenting: 21 Based on 1986 figures.

Orange

23. Massachusetts Society for the Prevention of Cruelty to Children (MSPCC)
The Armory, Main Street
Orange, Ma. 01364

Services: See # 13

HEALTH SERVICES: MASSACHUSETTS — HEALTH SERVICE AREA I

Pittsfield

24 County Adolescent Network of Berkshire, Inc. — Contact Person: Anne Lange
CANBE — 413-445-4324
Pregnant Adolescent Support System-PASS
150 North Street Rm. 22
Pittsfield, Ma. 01201
MAPPS-PPAP

Services: Intake and referral to 35 member agencies to provide coordinated and comprehensive services; CANBE comprised of 4 adolescent programs: Teenage Parent Program-alternative school for pregnant and parenting teens tutored by teachers from Pittsfield Schools; High Risk Mothers and Infants Program-VNA; PASS Project; dropin center; network with educational, health, human services agencies; plan to expand into areas of range of adolescent problems.

Funding Sources: Mass. DPH; Maternal and Child Health Block Grant (MIC)
Number of Teenagers Serviced Each Year: Pregnant: 100 Parenting: 150

25. Teen Parent Program — Contact Person:
Stearns School — 413-443-2530
Lebanon Ave.
Pittsfield, Ma.

Services: An alternative school for pregnant and parenting teens; services provided include: academic tutoring, GED preparation; physical assessments of mothers and babies; childbirth preparation; health education; nutrition counseling and education; individual and group counseling; exercise classes; Home Economics; Child Development classes; on-site nursery and transportation for Pittsfield residents; collaboration with Pittsfield School Dept., VNA, WIC, Berkshire Center for Families and Children, Right to Life; Berkshire Training and Employment; Family Planning.
Funding Sources: City of Pittsfield
Number of Teenagers Serviced Each Year: Approximately 35 pregnant and parenting teenagers.

26. Visiting Nurse Association — Contact Person: Joyce Hall
400 Columbus Ave. — 413-443-7221
Pittsfield, Ma. 01201
High Risk Mother and Infant Program

Services: Home visits that include: prenatal and post natal nursing care; physical assessments of infants and children; parenting skills; nutrition assessment and education; monitoring growth and development; child birth preparation; outreach; collaboration with CANBE, Teenage Parent Program, Division of Social Services.
Funding Sources: Medicare, Medicaid, Blue Cross, HMO, Veterans, Government, Private.

HEALTH SERVICES: MASSACHUSETTS — HEALTH SERVICE AREA I

Springfield

27. Baystate Medical Center OB/GYN Ambulatory Services
789 Chestnut Street — Contact Person:
Springfield, Ma. 01199 — 413-787-5346
Wesson Women's Clinic

Services: 3 clinic sites: Wesson Women's Clinic, Neighborhood Health Center, Brightwood Riverview Health Center; full range OB/GYN care including prenatal, postpartum, family planning, gynecological; onsite nutritionists, bilingual health aide, counselors-1 to 1 teaching; social service workers, parent education groups; nurse practitioner, nurse midwives, OB/GYN residents and faculty.
Funding Sources: Insurance, 3rd party reimbursement, self-pay; MIC grant for several staff positions.
Number of Teenagers Serviced Each Year: Pregnant: 325 Parenting: 350
Based on 1985 figures.

28. Brightside (Our Lady of Providence Children's Center) — Contact Person:
2112 Riverdale Street — 413-788-7366
W. Springfield, Ma. 01089

Services: Federal Adolescent Family Life Grant, begun in 1985-expanded services: case management, social work, nursing, volunteer parent aide services, research component; emphasis on minority youth; plans for adding employability development component; comprehensive program of services to adolescent parents and those at risk for early pregnancy; counseling and support services to teen mothers, and male and female prospective parents and extended families of both; community-based programs; outreach counseling and education services; infant and child care programs; preventive approaches; information and referral; psychosocial assessments; family life education; parenting education; skills and health education; individual, family and group counseling; support services in school and home; infant foster care during crisis or pre-adoptive; adoption services; legal services; advocacy; community education and training; resource bank; coordination, integration, linkage.
Funding Sources: Medicaid, Insurance, fees, DSS contracts, Federal grant-O.A.P.P.; Catholic Charities; sliding fees.
Number of Teenagers Serviced Each Year: 400+ Pregnant and Parenting

29. P.A.G.E., Young Parents — Contact Person:
YWCA — 617-732-3121
137 Chestnut Street
Springfield, Ma. 01103

Services: Health education; nursing staff teaches three health classes a week-prenatal and postnatal child development, nutrition, preparation for labor and delivery; counseling; Education; Alternative School; courses available; counseling-workshops, parenting skills, networking; counseling for mother and father; child-rearing techniques; communication skills; career development; social services; problem-solving; childbirth classes; job skills training.

HEALTH SERVICES: MASSACHUSETTS HEALTH SERVICE AREA I

Funding Sources: United Way
Number of Teenagers Serviced Each Year:

30. Services for Adolescent Family Enhancement Contact Person: Amina Ali
Project SAFE 413-737-9774
39 Mulberry Street
Springfield, Ma. 01105
MAPPS-PPAP
Services: Supportive individual counseling; family counseling; partner counseling, group counseling; parenting education; advocacy and transportation; referrals; case management; employment and training education; GED preparation; housing search; prevention education; network with school nurse and guidance; WIC; outreach-community education and speaking; administered by Family Planning Council of Western Mass; interagency agreements with Family Planning Services and WIC; planning and developing funding arrangement with local SDA employment and training program; volunteers.
Funding Sources: DPH
Number of Teenagers Serviced Each Year: Pregnant: 214 Parenting: 100

31. The Junior League of Springfield has a background paper for a proposal on sexuality education in the public schools, as part of C.A.R.E.S.- Citizens Advocating for Responsible Education about Sexuality).

32. Springfield Infant Mortality and Teen Pregnancy Coalition:
436 Dwight St. Room 309
Springfield, Ma. 01103 Contact Person: James Egan, M.D.
c/o Executive Office of Human Services-West Chairperson
Jerry Mogul
Coordinator

Services: Three task forces: Infant mortality and low birthweight prevention; Teen Pregnancy Prevention; Service coordination for pregnant and parenting teens; recommendations in two categories: Coalition Action and Supportive; recommendations contain four themes: education, services, awareness, and involvement. Over 100 individuals participate in the Task Force, from 70 organizations. Action Plan has been developed: goals: to reduce infant mortality and low birthweight rates; to reduce teen pregnancy; to increase pregnant and parenting teens' access to health care and social services; to help young parents complete high school and become economically self-sufficient. Coalition Action means those which will require new efforts; Supportive means those which support current or projected activities of existing agencies. Strategies to prevent teen pregnancy include: expanding life options; providing accurate education and information about family and sexuality health; to improve self-esteem, decision making and social resistance; enhancing family communications; increase access to contraceptive services; using media and public education. Supportive recommendations include: reducing school drop-out; implement "future awareness" program at elementary level; school-community partnerships; expansion of mentoring programs; after school programs; health curriculum; parent education workshops; church-based sexuality education and youth programs.

HEALTH SERVICES: MASSACHUSETTS HEALTH SERVICE AREA I

33. Westfield Area Teen Pregnancy Coalition
Chairperson: Anne Teschner, Community Representative, Office for Children
Coalition includes 30 members who are educators, health care professionals, clergy and community members, social services professionals; established by Westfield Area Council for Children and OFC staff. Conducting teen pregnancy needs assessments in area, and determine what resources are currently in existence.

34. Providence Hospital Prenatal Center Contact Person:
210 Elm St. 536-7385
Holyoke, Ma.

Services: Pregnancy testing; family-centered prenatal, intrapartal, and post-partal care; health education; social service assessment, counseling, and referral; nutrition assessments and support; childbirth education classes; member of Holyoke Service System for Pregnant and Parenting Teens, CHANS, Primary Care Committee, Human Services Network.
Funding Sources: DPH, MIC grant; 3rd party reimbursement; Providence Hospital.
Number of Teenagers Serviced Each Year: Pregnant: 200 Parents:

SURVEY RECOMMENDATIONS — Health Service Area 1

A total of 19 surveys were received and analyzed from this area. The recommendations are as follows:

1. 37% of the responses stated that child care is needed. This includes day care in schools and in communities. Some stated that this care needs to be specifically targeted to the needs of teens and their children.

2. *31.5% stated that housing is needed. This includes subsidized housing, group care, residential housing for teenagers, and transition to independent living programs. Shelters were also stated as a need.

3. 26% stated that family life education, sexuality education programs were needed. Some stated that family life education programs should be mandated in the schools.

4. 15.7% stated that school-based clinics should be established.

5. 10.5% stated that there should be funding for Healthy Start.

6. 10.5% stated that prenatal and postpartum services are needed.

7. 10.5% stated that prevention programs are needed, but did not specify type.

8. 10.5% stated that case management services are needed.

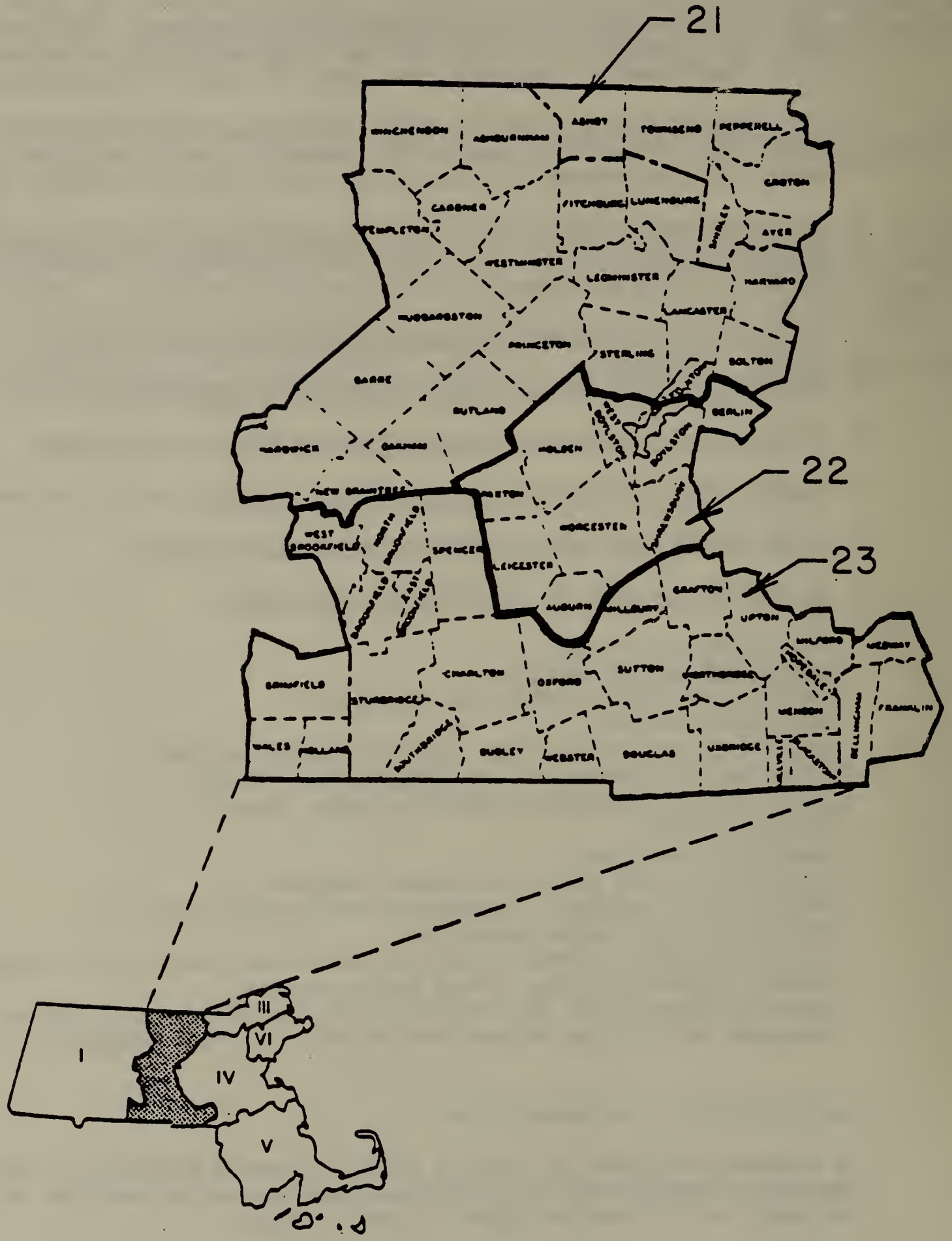
9. 5% stated that each of the following are needed:

   teen fathers services
   adolescent health services
   programs for school return and completion
   nutrition services
   group work for children who are sexual abuse victims
   group work for parents of children who are victims
   group work for offenders commiting sexual abuse
   funding of WIC
   community education
   expand funding of public assistance programs
   mobile health services - prevention and health education
   drug and alcohol abuse prevention
   cities should be allowed to develop individual models for health education, student health services, mental health services
   the state should have the responsibility for dealing with the social consequences to young mothers and society, for teen pregnancy

3 surveys gave no recommendations

* A problem identified for housing needs by service providers is that Section 8 certificates for subsidized housing are not provided to teens who want to, or need to, share in group housing.

HEALTH SERVICE AREA II



Massachusetts Cities and Towns: Teenage Births, 1984-1985

Health Service Area 2: Total Teen Births: 1984-1009 1985-1036

	12-17		18-19		Total Teen Births	
	1984	1985	1984	1985	1984	1985
Ashburnham	1	0	3	3	4	3
Ashby	0	0	0	0	0	0
Auburn	3	4	8	10	11	14
Ayer	6	10	22	28	28	38
Barre	3	1	4	4	7	5
Bellingham	6	4	10	11	16	15
Berlin	0	0	0	0	0	0
Blackstone	3	3	10	4	13	7
Bolton	0	0	1	1	1	1
Boylston	1	0	0	0	1	0
Brimfield	0	0	2	2	2	2
Brookfield	2	3	3	6	5	9
Charlton	1	5	10	8	11	13
Clinton	6	12	21	21	27	33
Douglas	4	0	7	3	11	3
Dudley	3	4	8	2	11	6
E. Brookfield	1	1	2	1	3	2
Fitchburg	20	28	60	72	80	100
Franklin	2	2	12	17	14	19
Gardner	13	11	22	31	35	42
Grafton	5	3	11	5	16	8
Groton	1	0	1	4	2	4
Hardwick	1	0	4	0	5	0
Harvard	0	0	0	1	0	1
Holden	0	1	5	1	5	2
Holland	1	0	2	2	3	2
Hopedale	0	2	1	2	1	4
Hubbardston	0	2	1	0	1	2
Lancaster	1	0	1	5	2	5
Leicester	3	2	7	8	10	10
Leominster	17	12	41	50	58	62
Lunenenburg	4	1	5	4	9	5
Medway	3	3	5	8	8	11
Mendon	1	1	0	1	1	2
Milford	8	6	19	18	27	24
Millbury	4	3	10	6	14	9
Millville	1	0	2	4	3	4
New Braintree	0	1	4	0	4	1
No.Brookfield	1	1	7	1	8	2
Northbridge	7	3	22	15	29	18
Oakham	0	1	0	0	0	1
Oxford	2	9	12	16	14	25
Paxton	0	0	0	0	0	0
Pepperell	2	2	7	6	9	8
Princeton	0	0	1	2	1	2
Rutland	0	0	8	1	8	1
Shirley	1	5	4	8	5	13
Shrewsbury	3	3	9	8	12	11

Health Service Area 2

City/Town	12-17 1984	12-17 1985	18-19 1984	18-19 1985	Total Teen Births 1984	Total Teen Births 1985
Southbridge	16	11	28	32	44	43
Spencer	3	5	24	19	27	24
Sterling	0	4	3	4	3	8
Sturbridge	2	1	3	4	5	5
Sutton	1	3	6	4	7	7
Templeton	3	2	1	3	4	5
Townsend	2	1	4	1	6	2
Upton	1	2	1	2	2	4
Uxbridge	3	3	5	8	8	11
Wales	1	0	0	0	1	0
Webster	7	9	20	23	27	32
W. Boylston	0	0	2	2	2	2
W. Brookfield	1	0	1	2	2	2
Westminster	0	2	1	1	1	3
Winchendon	9	11	16	12	25	23
Worcester	101	116	111	200	212	316

HEALTH SERVICES: MASSACHUSETTS HEALTH SERVICE AREA II

Fitchburg

1. Alternatives for Parenting Teens (APT) Contact Person:
283 Main Street 617-343-6259
Fitchburg, Ma. 01420
Operates in Gardner, Winchendon, Ayer
Services: Weekly support group meetings, include discussions and guest speakers on topics such as child development, housing, birth control, network of available services; behavior modification; home visits; child care during groups, transportation to groups; local hospitals for referrals; nurses for referrals; parenting skills training.
Funding Sources: DSS grant; no fee.
Number of Teenagers Serviced Each Year: Pregnant: average 2 a year; Parents: maximum of 24 a year.

2. Pro Health Contact Person:
283 Main Street 617-345-6272
Fitchburg, Ma. 01420

Services: Family Planning: pregnancy testing, reproductive health services, counseling, referrals; WIC program: nutritional services and education, counseling, referrals to health and social services; Directs APT Program: support groups and psychosocial supports; leadership development, counseling, parenting skills development, life goals development; Community health education. Outreach in schools, community; Parent Communication Effectiveness Training for parents of teenagers; local Healthy Start Coalition; health component of the Montachusett Opportunity Council.
Funding Sources: Federal:Public Health Service; State: DPH, DSS; United Way
Number of Teenagers Serviced Each Year: Pregnant and Parenting: Approx. 40% of WIC clients; approx. 60% of Family Planning Clients; approx. 25 in support groups.

Hopedale

3. Community Counseling Center of Contact Person:
Blackstone Valley, Inc. 617-473-6723
101 Mill St.
Hopedale, Ma. 01747

Leominster

4. Pregnancy Testing Center Contact Person;
10 Monument Square Room 5A 617-534-8421
Leominster, Ma. 01453

Services: Counseling; pregnancy testing; referral; 24-hour hotline; video presentation; outreach to schools when requested; parenting sessions; Healthy Start Coalition.
Funding Sources: Private.
Number of Teenagers Serviced Each Year: Pregnant: 500 Parents: 200

HEALTH SERVICES: MASSACHUSETTS — HEALTH SERVICE AREA II

N. Grafton

5. Job Corps Recruitment, U.S. Dept. of Labor
(see Employment/Job Training Programs)

Oxford

6. Lighthouse for Women — Contact Person: 617-987-3261
P.O. Box 592 345 Main St.
Oxford, Ma. 01540

Services: Residential maternity care; prenatal and postnatal care; adoption services; counseling; job training; GED future planning; preparation for childbirth classes; limited services in schools; maternity home on site; work with parents of pregnant and parenting teenagers.
Funding Sources: Private individuals and area churches.
Number of Teenagers Serviced Each Year: Pregnant: 15 Parents: Indirect services

Worcester

7. Catholic Charities of the Diocese of Worcester, Inc. — Contact Person: Rev. Msgr. Leo J. Battista 617-798-0191
15 Ripley Street
Worcester, Ma. 01610

Services: Pregnancy testing; counseling; outpatient/Inpatient clinic; residential care; medical, legal services; parenting sessions; spiritual counseling; aftercare group; sessions for single parents; infant foster care; adoption; alcoholism counseling; community and school outreach programs; collaboratives with other agencies.
Funding Sources: Public and private.
Number of Teenagers Serviced Each Year: Pregnant: 538 Parents: 72

8. Children's Friend Society — School Age Mothers SAM — Contact Person: Carol Epstein, LCSW 617-753-5425
21 Cedar St.
Worcester, Ma. 01609
SAM: Louise Caswell, R.N. Health Coordinator

Services: Comprehensive Services to teen parents; School Age Mothers Program (in collaboration with Worcester Public Schools) and Outreach Programs: School Age Mothers (SAM): provides prenatal and postnatal health education, social services, parenting instruction and infant care, located at 73 Lancaster St., Worcester; academic program provided by Worcester Public Schools; all services provided in single setting; individual and group; parenting training; information and assistance; Outreach: workers visit teen at home to help locate child care services, get financial aid, find adequate housing, help with finishing of education, find a job or job training; information on community resources-family planning, health care, recreation, self-help groups, caring for baby; Peptalk: Parent Educators Program: workshops, 10 hours of training; prepares parents to be the primary sexuality educators of their children.
Funding Sources: DSS-Public-Private Partnership Program with donations from City of Worcester and United Way, endowment income, private foundations, individual contributions.

HEALTH SERVICES: MASSACHUSETTS — HEALTH SERVICE AREA II

Number of Teenagers Serviced Each Year: Approx. 120 pregnant and parenting teenagers

9. Family Health and Social Service Center — Contact Person: 617-756-3528
875 Main Street +
Worcester, Ma. 01610

Services: Primary health care; mental health services; WIC nutrition services; dental care; injury prevention; outreach to schools-latchkey-injury prevention; member of regional Task Force on Prevention of Low Birthweight and Infant Mortality; parenting sessions; counseling.
Funding Sources: U.S. Dept. of Health and Human Services; Mass. DPH, DPW, UMass Medical Center.
Number of Teenagers Serviced Each Year: Pregnant: 49 Parents: 250

10. Family Planning Service of Central Mass. — Contact Person: Michael Mazloff
71 Elm Street +
Worcester, Ma. 01602

Services:

Funding Sources:

Number of Teenagers Serviced Each Year:

11. Great Brook Valley Health Center, Inc.
32 Great Brook Valley Ave.
Worcester, Ma. 01605

Services:

Funding Sources:

Number of Teenagers Serviced Each Year:

12. Health Awareness Services of Central Mass., Inc. + — Contact Person: Frances Anthes, LCSW Program Coordinator 617-756-5454
71 Elm Street
Worcester, Ma. 01609
MAPPS-CAHP
Services: Through ACCESS program, privide health care and social services; services during pregnancy and for two years following the baby's birth; counselors based at area hospitals and health center, as well as at administrative office; services include case management, advocacy, career counseling, childbirth education, nutritional counseling; expanded services to include 18 and 19 year olds; outreach to schools and community; individual and group sessions; adolescent health care; family life programs; home visits; life planning courses; presentations to PTA, PTO; parents of teenagers; linkage with 60 area agencies; Worcester Teen Pregnancy Network.

+ = Member of Worcester Teen Pregnancy Network

Funding Sources: DPH, DSS, March of Dimes Stoddard Charitable Trust, United Way of Central Mass.
Number of Pregnant and Parenting Teenagers Serviced Each Year: Pregnant: 125 new pregnant clients annually; annual caseload of 400-approx. 200 clients who are pregnant for some part of year; 200 clients who are parents for some part of year.

13. Marillac Manor of Catholic Charities Contact Person:
2 Granite Street 617-798-8709
Worcester, Ma. 01604

Services: Pregnancy Testing, Individual counseling, group sessions; follow-up groups; prenatal medical care-hospitalization; group residence; information and referral; continuing education; referral to housing; adoption services; natural family planning; outreach in schools and community; comprehensive services; Teen Task Force; Life-Line-24 hour phone.
Funding Sources: Bishop's Fund, DSS, Donations, Fees.
Number of Teenagers Serviced Each Year: Pregnant: 94 Parents: 51

14. Job Corps Recruiting Office
340 Main St., Room 355, Box 200
Worcester, Ma. 01614-0200
(See Job/Employment Training Programs)

15. MSPCC (Mass. Society for the Prevention of Cruelty to Children) Teen Parent Program Contact Person:
286 Lincoln St. 617-753-2967
Worcester, Ma. 01605

Services: Group counseling, transportation, child development and care services, activities/recreation, nutritional counseling, Teen Father outreach and counseling, Hispanic outreach and counseling, individualized parent aide(volunteer) program, extended family support group, referral to other community resources, and developmental assessment of the children of teen parents; outreach programs in community, school, parents of teens, group and individual counseling. Founding member of Worcester Area Network for Pregnant and Parenting Teens; Mass. Coalition of Pregnant and Parenting Teens.
Funding Sources: MSPCC income, private foundations, donors, federal grant(2yrs.) from National Center on Child Abuse and Neglect.
Number of Teenagers Serviced Each Year: Pregnant: Varies Parents: 75

16. PERNET Family Health Service Contact Person:
237 Millbury Street 617-755-1228
Worcester, Ma. 01605

Services: Maternal-child health nurses; at-home services; parenting groups; education and support services; member of Teen Pregnancy and Parenting Network.
Funding Sources:

Number of Teenagers Serviced Each Year:

17. St. Vincent Hospital
25 Winthrop
Worcester, Ma. 01604

Services:

Funcing Sources:

Number of Teenagers Serviced Each Year:

18. Teen CARE Program +
Burncoat Senior High School
179 Burncoat Street
Worcester, Ma. 01606

Contact Person: Betsy Wertheimer
Director
617-799-3322

Services: Transportation to and from school for mother and child; parenting education-daily class; on site role modeling; counseling; outreach follow-up; health monitoring, fulltime RN on site; full time day care for infants and toddlers; work with Worcester Area Network; all high schools; child development; outreach in school and community; support services for extended family; referrals, networking; Parenting Development Course; school completion.
Funding Sources: DSS Day Care contract/voucher; Worcester Public Schools; United Way.
Number of Teenagers Serviced Each Year: 20-30 teens/infants and toddlers.

19. Teen Pregnancy and Parenting Network:

Consists of ACCESS, Outreach, PERNET, Teen Parent Program, School-Age Mothers Program. These programs have a + beside their listing.

20. Teen Resource Book:

A resource directory put together by agencies and service providers in the Worcester area. Divided into several categories, gives name, address, phone, type of service, description of program, and states fee, if there is a fee.

21. UMass Adolescent Services
55 Lake Ave. North
Worcester, Ma. 01605

22. Worcester Pregnancy Counseling Service
110 June Street
Worcester, Ma. 01602

23. Youth Opportunities Upheld, Inc. YOU, Inc.
507 Main Street
Worcester, Ma. 01608

Worcester Public Schools, see School Age Mothers Program SAM #8 and Teen CARE Program #18

SURVEY RECOMMENDATIONS HEALTH SERVICE AREA II

A total of 14 surveys were received and analyzed from this area. The recommendations are broken down as follows:

1. 57% of the responses stated that family life education, sexuality education, health education are needed in comprehensive programs.

2. 35.7% stated that family planning services and birth control accessibility were needed.

3. 35.7% stated that funding was needed for non-reimbursable services such as outreach, case management and education; information services, nutritional and nurturance programs, and funding in general for more services, or for the extension of services and servicing components. Several respondents stated that services should be funded continuously so that programs would not always be threatened and endangered.

4. 28.5% stated that life options programs, employment opportunities, and economic/emotional opportunities were needed. Programs such as DPW-ET Choices were cited as needing continuity and expansion.

5. 21.4% stated that housing-transitional and residential programs, and shelters are needed.

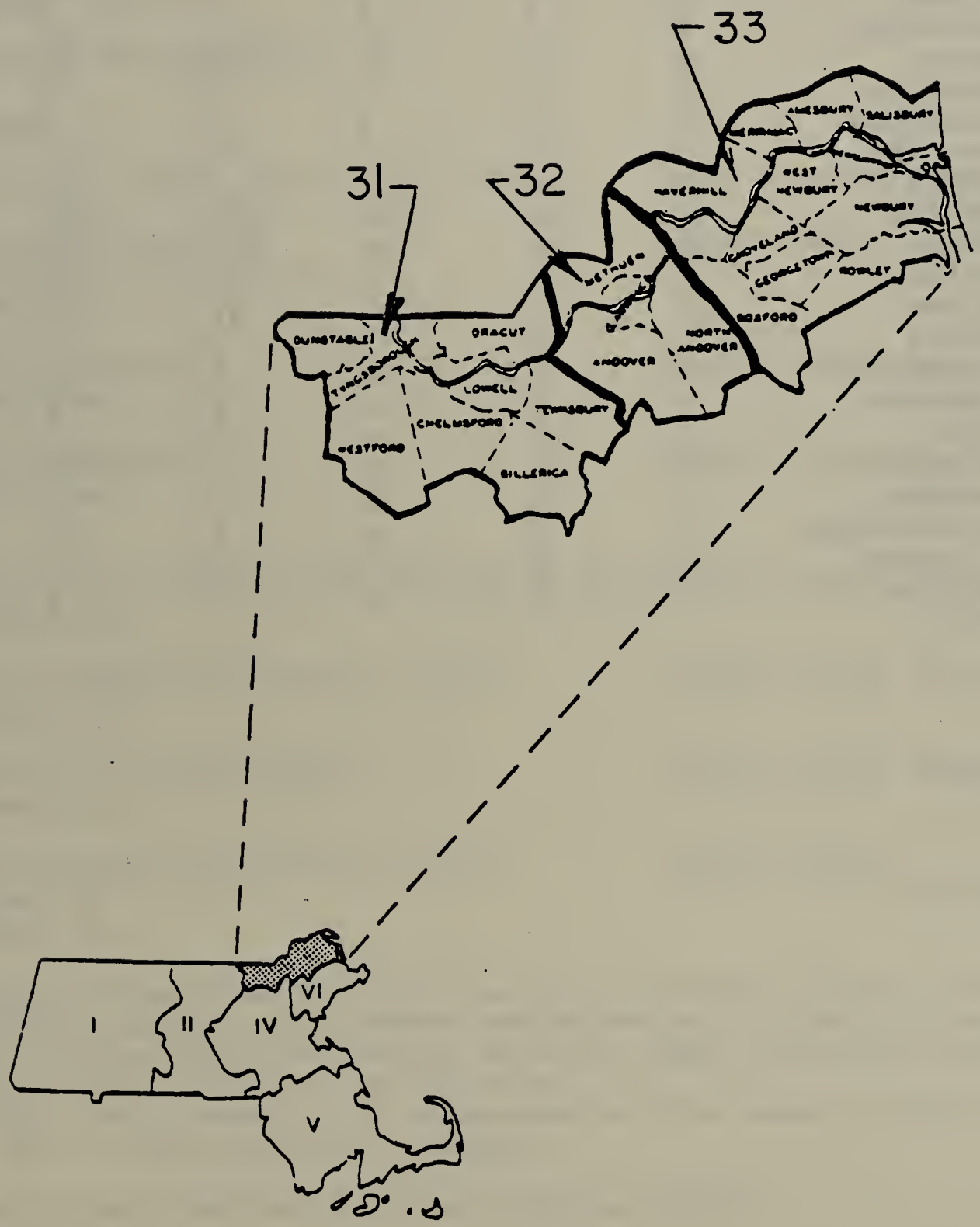
6. 21.4% stated that prevention programs are needed. These did not specify particular prevention programs, such as sexuality education and contraceptive use, or at what point, or by type, these programs should be developed.

7. Other recommendations fall into these categories:

14% stated that support programs for fathers are needed.
14% stated that parenting education programs are needed.
14% stated that basic skills education was needed.
14% stated that school-based health programs are needed.
14% stated that pre-vocational and vocational education programs are needed.
7% stated that the following are needed-the 7% applies to each of them:

Alternative Education
Support for DPH and DSS Programs
Healthy Start
Leadership Development
School Parent Support Programs
Adoption Incentives

HEALTH SERVICE AREA III



Cities and Towns in Massachusetts: Teenage Births 1984-1985

Health Service Area 3: Total Teen Births: 1984-818 1985- 853

City/Town	#Teen Births 12-17 1984	12-17 1985	18-19 1984	18-19 1985	Total Teen Births 1984	Total Teen Births 1985
Amesbury	3	7	24	24	27	31
Andover	1	5	6	7	7	12
Billerica	10	10	23	18	33	28
Boxford	0	1	1	1	1	2
Chelmsford	4	7	10	11	14	18
Dracut	6	6	15	14	21	20
Dunstable	0	0	1	3	1	3
Georgetown	1	0	4	4	5	4
Groveland	4	0	7	3	11	3
Haverhill	31	32	62	51	93	83
Lawrence	101	100	145	173	246	273
Lowell	92	86	156	175	248	261
Merrimac	0	1	2	2	2	3
Methuen	14	13	20	31	34	44
Newbury	1	2	1	1	2	3
Newburyport	9	5	13	9	22	14
N. Andover	4	5	4	5	8	10
Rowley	0	0	5	2	5	2
Salisbury	3	3	6	4	9	7
Tewksbury	7	3	13	13	20	16
Tyngsborough	1	2	4	8	15	10
W. Newbury	0	0	0	1	0	1
Westford	0	2	4	3	4	5

HEALTH SERVICES: MASSACHUSETTS — HEALTH SERVICE AREA III

Haverhill

1. Healthworks — Contact Person: Joan Fox
Pregnant and Parenting Program — 822-7700
40 Buttonwood Ave.
Haverhill, Ma. 01830
MAPPS-PPAP
Services: See #12

2. Visiting Nurse Association

Lawrence

3. Big Brothers and Big Sisters Association + — Contact Person: Gretchen Arntz, Director

4. Bon Secours Hospital + — Contact Person: Janet Johnston, Clinical Director
Maternal and Child Health
Lawrence, Ma.

5. Catholic Charities + — Contact Person: Maureen Bernard, Director
Lawrence, Ma.

6. Centro Panamericano + — Contact Person: Jorge Santiago, Exec. Director
Lawrence, Ma.

7. Department of Training and Manpower Development+ — Contact Person: Barbara Zeimetz, Planner
Lawrence, Ma.

8. Greater Lawrence Family Health Center+ — Contact Person: Maria Durham
Lawrence, Ma.

9. Greater Lawrence Home Health + — Contact Person: Peggy Abrams
Lawrence, Ma.

10. Greater Lawrence Mental Health Center+ — Contact Person: 683-3128
351 Essex St.
Lawrence, Ma.

Services: Agency does not have a specific program for pregnant/parenting teens. Cooperative agreement with Lawrence and Methuen public schools to provide mental health services within the schools, and some pregnant teens have been seen for therapy/referral assistance by clinicians.
Funding: Fees charged; do not refuse services, free care provided through agreement with public schools; Medicaid; insurance

11. Greater Lawrence Regional Vocational Technical School+
Lawrence, Ma.

12. Healthworks + — Contact Person: 682-5292
88 Franklin Street
Lawrence, Ma. 01840
MAPPS-CAHP

+ Member of Lawrence Adolescent Pregnancy Prevention and Parenting Coalition discussed at end of this section.

HEALTH SERVICES: MASSACHUSETTS — HEALTH SERVICE AREA III

Haverhill

1. Healthworks — Contact Person: Joan Fox, 822-7700
   Pregnant and Parenting Program
   40 Buttonwood Ave.
   Haverhill, Ma. 01830
   MAPPS-PPAP
   Services: See #12

2. Visiting Nurse Association

Lawrence

3. Big Brothers and Big Sisters Association + — Contact Person: Gretchen Arntz, Director

4. Bon Secours Hospital + — Contact Person: Janet Johnston, Clinical Director
   Maternal and Child Health
   Lawrence, Ma.

5. Catholic Charities + — Contact Person: Maureen Bernard, Director
   Lawrence, Ma.

6. Centro Panamericano + — Contact Person: Jorge Santiago, Exec. Director
   Lawrence, Ma.

7. Department of Training and Manpower Development + — Contact Person: Barbara Zeimetz, Planner
   Lawrence, Ma.

8. Greater Lawrence Family Health Center + — Contact Person: Maria Durham
   Lawrence, Ma.

9. Greater Lawrence Home Health + — Contact Person: Peggy Abrams
   Lawrence, Ma.

10. Greater Lawrence Mental Health Center + — Contact Person: 683-3128
    351 Essex St.
    Lawrence, Ma.

    Services: Agency does not have a specific program for pregnant/parenting teens. Cooperative agreement with Lawrence and Methuen public schools to provide mental health services within the schools, and some pregnant teens have been seen for therapy/referral assistance by clinicians.
    Funding: Fees charged; do not refuse services, free care provided through agreement with public schools; Medicaid; insurance

11. Greater Lawrence Regional Vocational Technical School +
    Lawrence, Ma.

12. Healthworks + — Contact Person: 682-5292
    88 Franklin Street
    Lawrence, Ma. 01840
    MAPPS-CAHP

+ Member of Lawrence Adolescent Pregnancy Prevention and Parenting Coalition discussed at end of this section.

12. Services: Advocacy, liaison, referrals; parenting skills education, home visits, adjustments to change; counseling regarding assertiveness training, relationship issues with family, partner, peers; GED; employment linkage; information-community resources regarding AFDC, legal aid, day care, housing, education; WIC.
Funding Sources: Public
Number of Teenagers Serviced Each Year: available under Lowell Healthworks

13. Lawrence General Hospital +
Prenatal Care
Lawrence, Ma. 01840
Contact Person: Lorraine Ott

14. Lawrence Public Schools
58 Lawrence Street
Lawrence, Ma. 01840
New Beginning Program
Contact Person: Susan O'Neill
Coordinator of
Occupational Programs
686-7701

Services: Child care available through Community Day Care, Inc. and DSS; two basic components of program; parenting/life skills instruction and counseling/ support services; Marilyn Twombly of School Home Economics Dept. and Mary Santa Cruz Trout, Bilingual Social Worker, co-lead discussions with groups designed to foster peer interactions and support; group members are teen mothers, pregnant teens, fathers and babies; importance of high school diploma is stressed, but participants do not have to be enrolled in an education program; discussions about prenatal development, child birth, family planning, nutrition, child development, home management, career and life planning; guest speakers from other agencies discuss services available; personal counseling and support services provided to assist students with school schedules, make referrals, conduct home visits, arrange home tutoring; Lawrence Infant/Toddler Program provides quality child care and support services for children of mothers who are attending high school; transportation provided for mother and child.
Funding: Public
Number of Teenagers Serviced Each Year: Pregnant: 17 Parents: 29

15. Merrimac Valley Health Planning Council+
Lawrence, Ma. 01840
Contact Person: Loretta Uhlik
Project Coordinator

16. Merrimac Valley Pro Life +
Lawrence, Ma.
Contact Person: Doreen Pacheco

17. Project Goodstart, MSPCC +
Lawrence, Ma.
Contact Person: Kathy Munro

18. The Psychological Center
Lawrence, Ma.
Contact Person: Hillary Terkewitz

Lowell

19. Healthworks, A Family Life Resource Center — Contact Person:
125 Perry Street — 459-6871
Lowell, Ma. 01852 Admin. Office — 452-5562

MAPPS-CAHP

Services: Counseling- Case Management model: Home Visits, advocacy, education, some transportation, extensive referral network for related and needed services; parenting support groups, parenting skills; model is designed to provide services from pregnancy testing onward, providing ongoing counseling and advocacy services set up as an individual service plan; in-school counseling and support; outreach to agencies; weekly groups at all three sites; extensive collaboration and cross referrals; birth control services
Funding Sources: DSS, DPH
Number of Teenagers Serviced Each Year: Includes screening and short-term services; Pregnant and Parenting Teens at all 3 sites-approximately 150.

20. Teen Health Service — Contact Person:
St. John's Hospital — 458-1411
Hospital Drive — Ext. 446
Lowell, Ma. 01852
MAPPS-CAHP

Services: Pregnancy testing; referral; individual and family counseling; consultant health care provider to schools and other servicing pregnant and parenting adolescents; primary health care for parenting adolescents; post-abortion examinations; parenting group YWCA; Lowell VOKE; collaboratives with YWCA, Vocational High School; church groups; Tewksbury H.S.; Andover High School; Dracut High; many other schools on request; primary health care to male and female adolescents; psychiatric evaluations and treatment; pregnancy testing; outreach educational programs.
Funding Sources: DPH, MCH funds; 3rd party; Medicaid; sliding scale or provide free services on ability to pay.
Number of Teenagers Serviced Each Year: Pregnant: 250 Parents: 85

21. Merrimack Valley Catholic Charities + — Contact Person:
70 Lawrence Street — 452-1421
Lowell, Ma. 01852

Services: Individual and group counseling, adoption and foster care; information and referral; case management, family life education; psychological testing; developing school counseling in Haverhill; coalition members in Lawrence, Haverhill; collaborative work with Cambodian Mutual Assistance Association in Lower, services to newcomer population.
Funding Sources: State Contracts; 3rd party insurance; fees, fund raising, in-kind.
Number of Teenagers Serviced Each Year: Total: 30 Pregnant: 2 Parents: 10

22. Greater Lowell YWCA
Family Support Center
206 Rogers St.
Lowell, Ma. 01852

Contact Person: 454-5405
Brigitte Weible
Lorinda Katz

Services: GED/ABE and Job-readiness program; career counseling and life management classes for young parents, 16-24, receiving AFDC, General Relief, Refugee Assistance; Parenting Program - group discussions, meeting needs of children and own needs; child care available; transportation to and from group; Young Parents Initiative Program - Parenting Skills Training; Parent Aide Program- support to parents through development of nurturing, non-judgmental relationships; improve self-esteem and encourage emotional development; weekly meetings, phone contacts; role modeling, support and teaching; prevention of abuse and neglect; strengthen parent-child relationship; utilize community resources; services Lowell area male and female parents from Hispanic community.

Lawrence Teen Pregnancy Action Plan

Objectives are to reduce teen birth rate, increase pregnant and parenting teens access to health care and social services, help young parents complete high school and become economically self-sufficient; structure: a Coordinating Committee and three task forces: Prevention, Health of Mother and Child, Education and Economic Self-sufficiency; issues are need for case management, community education, information and referral improvement, school-based adolescent clinic; outreach for at-risk populations, including males; comprehensive health and sex education in all schools; develop culturally diverse services; bilingual services are needed; have developed cards for agencies and groups resources for teenagers; facilitate parental involvement; recreational programs and youth employment programs.

SURVEY RECOMMENDATIONS HEALTH SERVICES AREA III

A total of 6 surveys were received and analyzed from this area. The recommendations are broken down as follows;

50% stated that housing was needed. Housing needs included Transition to Independent Living, expansion of housing to low income persons, including teens.

33% stated that school-based clinics should be established, with a comprehensive range of services.

16.6% stated that each of the following are needed:

free transportation in community areas
specialized school programs
GED programs
increased AFDC benefits
male teen programs
better prenatal care
tracking
community day care
school-based day care
health professionals to assess the children of teens
housing, contingent on employment training completion
recreational activities
parenting role models/mentor programs
expanded funding

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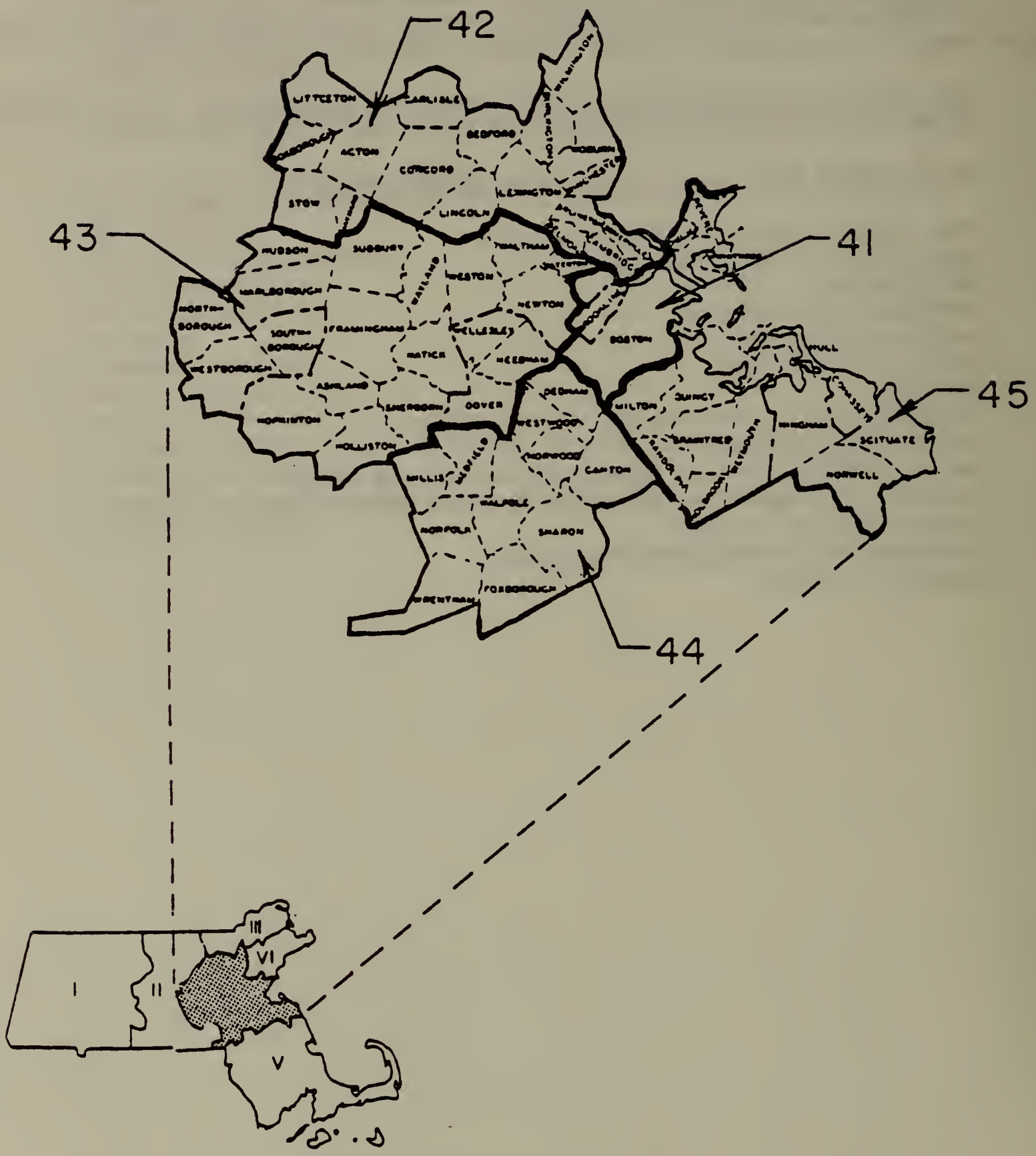
HEALTH SERVICE AREA IV



Cities and Towns in Massachusetts: Teenage Births 1984-1985

Health Service Area 4: total teen births: 1984-1965 1985-1960

City/Town	#Teen Births 12-17 1984	12-17 1985	18-19 1984	18-19 1985	Total Teen Births 1984	Total Teen Births 1985
Acton	1	0	4	1	5	1
Arlington	5	3	11	8	16	11
Ashland	0	0	2	6	2	6
Bedford	1	2	2	2	3	4
Belmont	0	0	4	3	4	3
Boston	438	468	694	724	1132	1192
Boxborough	1	1	6	1	7	2
Braintree	8	4	15	7	23	11
Brookline	0	2	5	5	5	7
Burlington	7	2	8	5	15	7
Cambridge	24	32	38	36	64	68
Canton	1	3	4	3	5	6
Carlisle	0	1	0	1	0	2
Chelsea	38	28	30	41	68	69
Cohasset	0	1	1	5	1	6
Concord	0	2	2	0	2	2
Dedham	3	4	7	4	11	8
Dover	0	0	0	0	0	0
Foxborough	4	3	4	5	8	8
Framingham	11	10	24	38	35	48
Hingham	2	0	4	5	6	5
Holbrook	3	3	6	3	9	6
Holliston	1	0	4	1	5	1
Hopkinton	2	1	11	3	13	4
Hudson	7	1	15	15	22	16
Hull	5	4	10	13	15	17
Lexington	2	0	8	0	10	0
Lincoln	0	0	0	0	0	0
Littleton	0	0	4	4	4	4
Marlborough	9	7	28	21	37	28
Maynard	3	4	8	5	11	9
Medfield	0	1	3	1	3	2
Millis	0	0	3	3	3	3
Milton	3	3	4	1	7	4
Natick	5	4	12	6	17	10
Needham	0	1	1	2	1	3
Newton	3	1	7	10	10	11
Norfolk	0	0	3	4	3	4
Northboro	3	2	5	5	8	7
Norwell	2	0	3	3	5	3
Norwood	5	2	11	9	16	11
Quincy	14	15	40	42	54	57
Randolph	5	0	11	9	16	9
Revere	6	5	22	19	28	24
Scituate	3	4	3	7	6	11
Sharon	1	2	4	2	5	4
Sherborn	0	0	1	1	1	1

Cities and Towns in Massachusetts: Teenage Births 1984-1985

Health Service Area 4: Total Teen Births: 1984-1965 1985-1960

City/Town	# Teen Births 12-17 1984	12-17 1985	18-19 1984	18-19 1985	Total Teen Births 1984	Total Teen Births 1985
Somerville	19	21	59	64	78	85
Southborough	0	0	1	1	1	1
Stow	0	0	2	0	2	0
Sudbury	2	1	1	0	3	1
Walpole	3	5	4	3	7	8
Waltham	10	13	32	18	42	31
Watertown	6	3	5	3	11	6
Wayland	0	0	2	0	2	0
Wellesley	0	1	1	1	1	2
Westborough	2	1	3	8	5	9
Weston	0	0	1	1	1	1
Westwood	0	2	3	1	3	3
Weymouth	19	11	29	33	48	44
Wilmington	3	4	10	5	13	9
Winchester	1	2	4	5	5	7
Winthrop	1	1	0	3	1	4
Woburn	5	7	13	24	18	31
Wrentham	1	0	5	4	6	4

HEALTH SERVICES: MASSACHUSETTS HEALTH SERVICE AREA IV

Arlington

1. Arlington Youth Consultation Center
12 Prescott Street
Arlington, Ma. 02174
Contact Person:
646-5880

Services: Individual, group and family counseling; one group for teen mothers; crisis intervention, emergency services, referral services. community outreach; home visits; counseling sessions in school; co-lead teen mothers group in Lexington with Replace.
Funding Sources:Town of Arlington, DSS, DMH, 3rd party; sliding fee scale.
Number of Teenagers Serviced Each Year: Pregnant: 4-5 Parents: 15

2. The Efficacy Committee, Inc.
297 Broadway
Arlington, Ma. 02174
Contact Person: Ray Hammond, MD
Executive Director

Services: Education is central factor in preparing minority youngsters to lead responsible, meaningful and fulfilling lives; promotes self-confidence; work on fear of failure, expectations of others, presence or lack of support for development in home, peer group, community; performance-related behaviors; moderate risk-taking, goal-setting, networking; assume responsibility for outcomes; student training

Boston

3. Action for Boston Community Development
178 Tremont St.
Boston, Ma. 02111
Contact Person: Mary Russell, Director
357-6000

Services: Family planning offers low cost Comprehensive Reproductive Health Services for men and women; workshops on parenting skills; Valueable Values-how to talk to your child about sex and other difficult issues; relationships; Birth Control; decision-making and pregnancy options; workshops; counseling
Funding Sources: sliding fee scale
Number of Teenagers Serviced Each Year: Pregnant: 1000 Parents: 1000

4. Big Sister Association of Greater Boston, Inc.
140 Clarendon St. Box 734
Boston Ma. 02117
P.A.I.R. Pregnant and Parenting Adolescent in Relationship
Contact Person: Jan Wiley, LICSW
Coordinator
267-4406

Services: Addresses special needs and problems of teenage mothers; PAIR gives pregnant and parenting teens a friend and role model; volunteer Big Sister to parenting teen; volunteer sees mother weekly for 4 hours minimum-per week for 18 months; supervision and ongoing referral and support services are provided by agency social worker.

HEALTH SERVICES: MASSACHUSETTS HEALTH SERVICE AREA IV

Funding Sources: United Way of Mass. Bay; Boston Foundation; numerous foundations, corporations, events, and individuals.
Number of Teenagers Serviced Each Year: Pregnant: 20 Parents: 20

5. Boston Children's Service Association
867 Boylston St.
Boston, Ma. 02116
Contact Person: Mary Byrne
267-3700

Services: Counseling; family planning, pregnancy decisions, post pregnancy issues; pregnancy prevention education; parenting education; foster care for baby and for teen mother and baby together; adoption services; independent living skills training; job placement, transportation; groups of pregnant and parenting teens in high school; groups for teens-male and female; home visits and school visits.
Funding Sources: DSS, DMH, United Way, private income, fees; some-no fee; Medicaid; private insurance.
Number of Teenagers Serviced Each Year: Pregnant: 30 Parents: 25

6. Adolescent Services
Dept. of Health and Hospitals
818 Harrison Ave.HOB 419
Boston, Ma. 02118
Contact Person: Howard Spivak,MD
Director
424-5199

Services:

Funding Sources:

Number of Teenagers Serviced Each Year:

7. Boston Youth Program
Boston City Hospital
818 Harrison Ave. H.O. 4th floor
Boston, Ma. 02118
Contact Person:
424-5196

MAPPS-CAHP
Services: Primary health care services; pediatrics; internal medicine, ob-gyn care; educational services around specific health issues; placement in job training programs; recreational activities; mental health services; have a number of entry points in Dorchester and Roxbury, including schools, courts, emergency rooms; referrals; several service sites.
Funding Sources:
Number of Teenagers Serviced Each Year;
Health Promotion Program: Outgrowth of Boston Youth Program; program consists of direct service projects for youths; school-based and community-based curricula; training for providers and community leaders, mass media campaigns; coordinate network of existing primary and secondary prevention efforts to facilitate interagency referrals; job training and employment service programs included; develop policy statement on prevention topics; resource for development of prevention strategies and research about relationships between interventions and outcomes.
Contact Person:

HEALTH SERVICES: MASSACHUSETTS — HEALTH SERVICE AREA IV

8. Community Health Services
818 Harrison Ave. Adm. Bldg.4
Boston, Ma. 02118
Contact Person: Dr. George Lamb
424-5266

Services:

Funding Sources:
Number of Teenagers Serviced Each Year:

9. Teen Line
818 Harrison Ave. HOB 422
Boston, Ma. 02118
Contact Person: 424-5700

Services: Information and referral on birth control, drugs/alcohol, job and training opportunities, depression, family problems, pregnancy, early parenting.
Funding Sources: Non-profit program sponsored by Boston Dept. of Health and Hospitals and Harvard Community Health Plan Foundation.

10. Bridge Over Troubled Waters
Family Life Center
147 Tremont St. at West St.
Boston, Ma.
Contact Person: Barbara Whelan
Barbara Scanlon
423-9575

Services: Parenting Education, Life Skills support, Individual counseling and parenting, child care while participating in group and individual meetings; skills learning-sewing, cooking, arts and crafts, home repairs, etc.; groups for parents with children in foster care; vocational/educational, GED services; services for runaways, drug/alcohol use; outreach, streetworkers; mobile health van; independent living; in-school programs, PTA, video presentations.
Funding Sources: DSS, Maternity Foundation, Private.
Number of Teenagers Serviced Each Year: Pregnant: 10 Parents: 50

11. Brigham and Women's Hospital
Adolescent Reproductive Health Service
75 Francis Street
Boston, Ma. 02115
MAPPS-PPAP
Contact Person: Angela Nicoletti, RNC
732-4750

Services: Young Parents' Prenatal Program; specific needs addressed of pregnant adolescents under 18 years; intake session-learn of services; prenatal care; childbirth classes; labor and delivery services and medical care; postpartum management in conjunction with primary providers of adolescent service; community outreach project; services to fathers and family members.
Funding Sources:
Number of Teenagers Serviced Each Year: 24 new patients accepted each month

12. Brigham and Women's Hospital
Consortium for Pregnant and Parenting Teens
75 Francis Street
Boston, Ma. 02115
Contact Person: Sylvia PerlmanPhD
Director
732-4034

HEALTH SERVICES: MASSACHUSETTS — HEALTH SERVICE AREA IV

Services: Five agencies: Adolescent Reproductive Health Service, Brookside Community Health Center, Southern Jamaica Plain Health Center, Crittenton-Hastings House, and City of Boston Community Health Nursing provide: pregnancy tests, birth control info. and services, VD tests and treatment, medical care for teens and their children, childbirth and parenting education, general medical care, counseling, alternative school services, home visits, outreach services.
Funding Sources: DPH, Inkind from Brigham and Women's Hospital
Number of Teenagers Serviced Each Year; Pregnant: 1083 Parents: 696

13. Cardinal Cushing Center — Contact Person:
1375 Washington St. — 542-9292
Boston, Ma.

Services: Counseling, supportive services, education GED preparation; life management skills, transportation, baby-sitting services while teenagers participate in program activities; peer support groups; outreach to schools and communities, as well as on-site.
Funding Sources: DSS, United Way, Archdiocese of Boston, Boston Foundation, Hyams Foundation.
Number of Teenagers Serviced Each Year: 48 total; 40% pregnant; 60% parents(varies)
Program also consists of Project Redirection, Proyecto A.M.O.R.-services to Hispanic pregnant and parenting teenagers: academic education, health education, family planning, counseling, job referrals, recreational activities. In past two years, services provided to 136 Hispanic teens; 50 adolescents are enrolled at any one time.

14. Catholic Charitable Bureau of Boston — Contact Person: Rev. Eugene McNamara
10 Derne Street — Dorien Moffitt
Boston, Ma. 02114 — Agnes Erickson
523-5165

Services: Counseling, prenatal care, foster care, hospital planning, adoption, housing and financial assistance for mother and child, supportive services; plans for additional services, family day care in Malden, Medford, Everett, Revere, Melrose; referrals, single parent counseling, several locations.
Funding Sources: United Way, Cardinal's Annual Appeal
Number of Teenagers Serviced Each Year:

15. Children's Hospital — Contact Person: Sue Perry, LICSW
Young Parents Program — 735-7701
300 Longwood Ave.
Boston, Ma. 02115
MAPPS-PPAP

Services: Pediatric care; medical care for teen mothers and fathers; gynecological care; birth control counseling and services; social services for teen parents and their families, including home visits; individual and group teaching about growth and development; parenting skills; young parents and their children can also be seen at Comprehensive Child Health Program-CCHP; access to vocational and educational opportunities; decision-making; follow up on child to 3 years
Funding Sources: DSS, DPH, in-kind from Children's Hospital
Number of Teenagers Serviced Each Year: 130-150 families, with 150-160 children.

HEALTH SERVICES: MASSACHUSETTS — HEALTH SERVICE AREA IV

16. City Mission Society
14 Beacon Street #507
Boston, Ma.
Contact Person:
742-6830

Services: Discussion groups in self-esteem, sexuality and substance abuse; programs are preventative in scope; arts programs, reading/tutoring; counseling; several collaborating agencies; community workshops.
Funding Sources: Private
Number of Teenagers Serviced Each Year: Pregnant: 1 Parents:

17. C.O.P.E.
530 Tremont Street
Boston, Ma. 02116
Coping with the Overall Pregnancy/Parenting Experience
37 Clarendon Street
Boston, Ma. 02116
Contact Person:
357-5588

Services: Individual and family counseling; information and referral; counseling in pregnancy, couple relationships, family issues, pregnancy decision-making, single parenting; post-abortion, unplanned pregnancy; child abuse, teenage pregnancy; support groups; parenting preparation program; community-based individual, couple, family and group counseling sessions located in several sites.
Funding Sources: Private, non-profit
Number of Teenagers Serviced Each Year: Varies for Pregnant and Parenting Teens

18. Crittenton Hastings House of the Florence Crittenton League
10 Perthshire Road
Boston, Ma. 02135
MAPPS-PPAP
Contact Person: Terri Sison
782-7600
CHANCES PROGRAM

Services: Community-based servicesCBS offers services to adolescents, women and families in need of prenatal, parenting, and reproductive health care services; Day Program offers comprehensive prenatal services to adolescents on-site; affiliated with Boston Public Schools and Brigham and Women's Hospital; Extended Services Program is a one to three year follow-up program-services offered on a home visit case management model focused on areas of : parenting skills, continuation of education, effective family planning; work with other providers; school-based program in Brighton High School-weekly class for pregnant and parenting students; 10th grade students may attend a teaching module on health education; workshops in Boston Schools on adolescent sexuality; comprehensive prenatal care services; individual and groups counseling; programs for parents of teens; social worker follows up after birth. Collaboratives.
Funding Sources: DSS Young Parents and Family Planning; foundations, grants, corporations, donations. DPW/ET program
Number of Teenagers Serviced Each Year: Pregnant: 90-100 Parents: 75

19. EDCO Youth Alternative
650 Beacon Street
Boston, Ma. 02215
Contact Person: Jerome Regan
Karen Gomsby

HEALTH SERVICES: MASSACHUSETTS HEALTH SERVICE AREA IV

Services:

Funding Sources:
Number of Teenagers Serviced Each Year:

20. East Boston Neighborhood Health Center
10 Cove Street
East Boston, Ma. 02128
Contact Person: Dr. James Taylor
569-5800

Services: Maternal and Child Health Program; Healthy Start Program; prenatal care: medical care

Funding Sources:
Number of Teenagers Serviced Each Year;

21. English High School CSAPP, Inc.
Comprehensive School-Age Parenting Program, Inc.
77 Avenue Louis Pasteur
Boston, Ma. 02115
Contact Person: Bette Bohlke-O'Gara
LICSW, Exec. Director
738-9034

Services: Also located at Jamaica Plain High School and Grover Cleveland Middle School; goals are to keep school-age parents in school; decrease medical risks associated with teen pregnancy; increase student's knowledge about parenting skills; encourage students to request and evaluate the information and services they need; decrease number of unplanned teen pregnancies; counseling; health care and nutrition; day care; communication skills; home tutoring; financial aid; help with employment and housing; child growth and development; groups-mothers/fathers
Funding Sources:
Number of Teenagers Serviced Each Year: Total: Approx. 200 male and female
Contact Persons: English High School: Marian DeVance or Michael Stiles-738-9034; Jamaica Plain High School: Sheryl Heyward, Michael Stiles-524-4951; Grover Cleveland Middle School: Marilyn Hughes-288-6681.

22. Jobs for Youth
312 Stuart Street
Boston, Ma. 02116
Contact Person: Gary Kaplan, Exec.Dir.
338-0815

Services:

Funding Sources:

Number of Teenagers Serviced Each Year;

23. Massachusetts Society for the Prevention of Cruelty to Children, MSPCC
43 Mount Vernon Street
Boston, Ma. 02108
Contact Person: Virginia Burns

Services: Parent Aide Program; Teen Parent Program; Project Good Start; Family Counseling; Infant Development Program

HEALTH SERVICES: MASSACHUSETTS — HEALTH SERVICE AREA IV

Funding Sources:

Number of Teenagers Serviced Each Year:

24. New England Medical Center, Dept. Child Psychiatry, Infant-Toddler Unit
171 Harrison Ave. Box 395
Boston, Ma.

Contact Person:
956-5768

Services: Counseling to pregnant/parenting teens around issues of pregnancy, delivery, early parenting and child development; school retention, maturational issues; mental health services; outreach; school visits; home visits; developmental assessments.
Funding: 3rd party reimbursements.
Number of Teenagers Serviced Each Year: Pregnant: 15-20 Parents: 15-20

25. South Boston High School
95G Street
South Boston, Ma. 02127

Contact Person: Marilyn Hurwitz
268-2751

Services: Health education curriculum, counseling; emphasis on adolescent issues, including sexuality, decision-making, peer pressure, media messages, conception, contraception, risks of teen pregnancies, parenting, prenatal growth and development; course required for 9th, 10 graders, and others may choose as an elective; Oasis-on-site social service program, includes a nurse practitioner from New England Medical Center; counseling, with parental consent, through pregnancy and through 3rd year of child's life; parenting skills, diagnostic testing, assistance in finding child care for return to school.
Funding Sources:

Number of Teenagers Serviced Each Year:

26. St. Margaret's Hospital
Family Life Services
90 Cushing Ave.
Boston, Ma. 02125
MAPPS-PPAP

Contact Person: Frances Kellogg-Troutman
Director
Mary Conroy
436-8600 ext.224
Sr. Marie Fuhrman

Services: Hotline; Pregnancy Testing; Prenatal Clinic; Prenatal Education and Classes; childbirth preparation classes; fertility awareness and human sexuality; natural family planning; nutritional assessment and counseling; classes for client and her labor support person-specifically for teens; pediatric clinic; parenting classes; individual/family counseling; family community workers-home visits and community contacts; adoption counseling and decision-making group; support groups; Residential Program for Pregnant Single Women-St. Mary's Home; School program for Pregnant Women; Educational and Career Counseling; outreach and education-schools. Use Community of Caring from Joseph Kennedy, Jr. Foundation-curriculum for adolescent sexuality, pregnancy, parenting, family planning and family living; family life curriculum; goals and life experiences; decision-making and self-esteem.

HEALTH SERVICES: MASSACHUSETTS HEALTH SERVICE AREA IV

Funding Sources: Office of Adolescent Pregnancy Programs (OAPP); Mass. Dept. of Public Health; Kennedy Foundation.
Number of Teenagers Serviced Each Year: Pregnant: 300 Parents:

27. South End Community Health Center
400 Shawmut Ave.
Boston, Ma. 02118

Contact Person: Tristram Blake
Executive Director
266-6336

Services:

Funding Sources:

Number of Teenagers Serviced Each Year:

28. United South End Settlements
566 Columbus Ave.
Boston, Ma. 02118

Contact Person: Freida Garcia
Executive Director
Peggy Brown
Family Life Programs
536-8610

Services:

Funding Sources:

Number of Teenagers Serviced Each Year:

29. Urban League of Eastern Massachusetts
236 Huntington Ave.
Boston, Ma. 02115

Contact Person: Donald Polk
Executive Director
266-3550

Services: Training, education; programs for teens to remain in school; Adoption Project; day care; health services referral; job counseling and placement; Employment/Training Program; vocational education; independence program; Male Responsibility Initiative Program.
Funding Sources: Corporate, state contracts; DSS and DPW; federal government; private contributions; National Urban League.
Number of Teenagers Serviced Each Year: Pregnant; varies Parents; 13-program canceled-difficult to keep teens in program.

30. WEATOC. We're Educators A Touch of Class
558 Massachusetts Avenue
Boston, Ma. 02118

Contact Person: Christine Bond
Claradine Moore-James
262-0221

Services: Family Health Education Program; Prevention Model Program; goal is healthy adolescent development through education and training for families; programs provide: theatrical presentations; peer training and counseling; self-esteem workshops; parent sex education workshops; patient waiting room health education for teens and pediatric clinics; speaking engagements; 8 week comprehensive sex education courses for 9-12 year olds, 13-15 year olds, 16-19 year olds;

HEALTH SERVICES: MASSACHUSETTS HEALTH SERVICE AREA IV

Funding Sources: Office of Adolescent Pregnancy Programs (OAPP); Mass. Dept. of Public Health; Kennedy Foundation.
Number of Teenagers Serviced Each Year: Pregnant: 300 Parents:

27. South End Community Health Center
400 Shawmut Ave.
Boston, Ma. 02118

Contact Person: Tristram Blake
Executive Director
266-6336

Services:

Funding Sources:

Number of Teenagers Serviced Each Year:

28. United South End Settlements
566 Columbus Ave.
Boston, Ma. 02118

Contact Person: Freida Garcia
Executive Director
Peggy Brown
Family Life Programs
536-8610

Services:

Funding Sources:

Number of Teenagers Serviced Each Year:

29. Urban League of Eastern Massachusetts
236 Huntington Ave.
Boston, Ma. 02115

Contact Person: Donald Polk
Executive Director
266-3550

Services: Training, education; programs for teens to remain in school; Adoption Project; day care; health services referral; job counseling and placement; Employment/Training Program; vocational education; independence program; Male Responsibility Initiative Program.
Funding Sources: Corporate, state contracts; DSS and DPW; federal government; private contributions; National Urban League.
Number of Teenagers Serviced Each Year: Pregnant; varies Parents; 13-program canceled-difficult to keep teens in program.

30. WEATOC. We're Educators A Touch of Class
558 Massachusetts Avenue
Boston, Ma. 02118

Contact Person: Christine Bond
Claradine Moore-James
262-0221

Services: Family Health Education Program; Prevention Model Program; goal is healthy adolescent development through education and training for families; programs provide: theatrical presentations; peer training and counseling; self-esteem workshops; parent sex education workshops; patient waiting room health education for teens and pediatric clinics; speaking engagements; 8 week comprehensive sex education courses for 9-12 year olds, 13-15 year olds, 16-19 year olds;

HEALTH SERVICES: MASSACHUSETTS HEALTH SERVICE AREA IV

WEATOC members are youth ages 8-21, adults, participating in various levels of training to prepare them to teach sex and health education classes; use of theatre as education tool; peer educators teach classes in reproductive anatomy and physiology, human reproduction, sexually transmitted infections/V.D.; birth control and sexual responsibility.
Funding Sources:

Number of Teenagers Serviced Each Year:

Brighton

31. Brighton Marine Hospital
Pediatric Clinic
77 Warren St.
Brighton, Ma. 02135

Contact Person: Mary Forbes
782-1620

Services:

Funding Sources:

Number of Teenagers Serviced Each Year:

32. Pregnancy Help of Greater Boston, Inc.
736 Cambridge Street
Brighton, Ma.

Contact Person:
782-5151

Services: Counseling regarding alternative to abortion; limited shelter homes; referral and information services; professional counseling, including adoption counseling; maternity and infant clothing and supplies support.
Funding Sources: Private
Number of Teenagers Serviced Each Year: Pregnant: 50 Parents:

33. Project PACT
77B Warren Street
Brighton, Ma. 02135

Contact Person: Gen. Woodruff
Director
783-7300

Services:

Funding Sources:

Number of Teenagers Serviced Each Year;

34. Pro-Life Office of the Archdiocese of Boston
St. Elizabeth's Foundation
159 Washington Street
Brighton, Ma. 02135

Contact Person;
783-5410

HEALTH SERVICES: MASSACHUSETTS HEALTH SERVICE AREA IV

Services: Project Rachel; Post-Abortion Reconciliation; counseling; The Good Shepherd: alternatives to abortion; help with housing, shelter; shelter homes provided-temporary or duration of pregnancy; host families provide shelter; services include maternity clothing, referrals for medical care and financial assistance; assistance with school/job plans; transportation, childbirth education, baby clothing; help with living arrangements after birth; preparations for parenting.
Funding Sources:

Number of Teenagers Serviced Each Year:

35. St. Elizabeth's Hospital
736 Cambridge Street
Brighton, Ma. 02135

Contact Person: Mary Ann Donaldson
Terry Vecchione
789-2436

Cambridge

36. Cambridge Community Services
Adolescent Parent Employability Program
99 Bishop Richard Allen Drive
Cambridge, Ma. 02139

Contact Person: Susan Golden
Wendy Martin
876-5214

Services: Developed in collaboration with Cambridge Rindge and Latin High School Adolescent Parenting Program; provides career exploration and employment services for pregnant and parenting teenagers who are enrolled in school; began in Sept., 1986; exploration of career options, develop marketable employment skills, enter occupations that offer opportunities for advancement, security, self-sufficiency; Mentor Linkage Component-matches students with volunteer women as role models and career counselors; mentors recruited in collaboration with Black Achievers, an organization of volunteer professionals and local business organizations; Work Experience Internships.
Funding Sources:
Number of Teenagers Serviced Each Year: up to 28 students per year

37. Cambridge Rindge and Latin School
Adolescent Parenting Program (APP)
459 Broadway
Cambridge, Ma. 02138

Contact Person: Sherry Trella
498-9211

Services: An alternative academic program to pregnant and parenting teenagers, who are high school students; five courses: Life Skills-science/health focussing on relevant health issues; Child Development-emphasis on parenting issues; Social Studies-addresses local services available to young parents, personal development; physical education program designed for pregnant and parenting women; support group; spaces also reserved in other "mainstream" Human Development and Child Development classes; counseling and assistance in accessing social services; home visits, make referrals and accompany young parents to appointments at other agencies; First Steps-infant/toddler center within school provides care for children of APP students who are between 6 weeks and 2 yrs., 9 months; fee based on family income; AFDC recipients must apply for child care subsidy.

HEALTH SERVICES: MASSACHUSETTS HEALTH SERVICE AREA IV

Funding Sources: Child Care Program financed through Cambridge School Dept., Mass. Dept. of Education Occupational Education Grant; subsidies financed by state via Voucher Day Care Project associated with Employment and Training Program; DSS grant.
Number of Teenagers Serviced Each Year; courses have capacity of 20 enrollees; child care-9 infants; 6 toddlers-varies.

38. Catholic Charities of Cambridge/Somerville Contact Person: Carol Klein
Somerbridge: Services to Young Parents 547-9566
99 Bishop Allen Drive
Cambridge, Ma. 02139

Services: Outreach program for young parents; supportive and educational services to individuals and groups seeking help with pregnancy and parenting matters; medical services-finding well baby care, getting gynecological care, getting family planning information, arranging emergency medical care; child care-getting information about child development, planning for day care, short term foster care; getting adoption services; help with school continuation, finding jobs, groups, understanding self as parent; help getting on welfare, Medicaid.
Funding Sources:
Number of Teenagers Serviced Each Year;

39. Concilio Hispano de Cambridge, Inc. Contact Person:
Cambridge Spanish Council
105 Windsor Street
Cambridge, Ma. 02139

Services:

Funding Sources:
Number of Teenagers Serviced Each Year:

40. Daybreak Contact Person:
1384 Massachusetts Avenue 576-1981
Cambridge, Ma. 02138

Services: Pregnancy testing; options counseling-information on abortion, adoption, parenting, fetal development, pregnancy support services; information and referral; discussions of sexuality issues/choices; advocacy-outreach, support, and counseling on regular basis through pregnancy; maternity and baby clothes/supplies; housing during pregnancy and for two months after birth; 18 years and over in private homes; clients can be assigned trained volunteer for support; labor coach, if needed-part of advocacy.
Funding Sources: Private donations.
Number of Teenagers Serviced Each Year; Pregnant; 71 ('85 figures) Parents: 15

HEALTH SERVICES: MASSACHUSETTS — HEALTH SERVICE AREA IV

41. Employment Resources, Inc.
50 Essex Street
Cambridge, Ma. 02139
The BEginnings Program
Contact Person: Cathy Qualitz
Melinda Mancini
492-0591

Services: Personal counseling; GED classes, including home tutoring; support services; childcare, transportation, weekly cash stipend ($20AFDC; $50 non-AFDC; vocational counseling; career exploration; job training placements; follow-up; weekly workshops around issues such as: improving parenting skills; managing stress; coping with depression; losing weight; quitting smoking; providing first aid; learning about risks of substance abuse; outreach in community; interagency collaboration. ET SITE
Funding Sources: Department of Education; OTEP; DPW
Number of Teenagers Serviced Each Year: Pregnant: approx.30 Parents: approx. 30

42. Mt. Auburn Hospital Women's Health Service
330 Mt. Auburn Street
Cambridge, Ma. 02238
Contact Person: Ellen Abele
499-5151
Linda Decker

Services: Prenatal and postpartum care; obstetrical and midwifery care based on a private model; prenatal education classes; social work: counseling and advocacy; community education programs; preventive health topics; sexuality and contraception education; collaboratives.
Funding Sources: Services are part of hospital.
Number of Adolescents Serviced Each Year: Pregnant: 11 prenatal patients

43. Planned Parenthood League of Massachusetts
99 Bishop Allen Drive
Cambridge, Ma. 02139
Contact Person: Nancy Drooker, M.Ed.
492-0518
492-0777 Counseling

Services: Medical services in Worcester that include contraception, STD screening, first trimester abortion; education programs; counseling and referral; telephone information and referral to approx. 1120 teens each year; variety of sex education programs provided in schools, community agencies, religious institutions; education and training; peer education program; collaborations.
Funding Sources: Foundations, corporations, private donors.
Number of Teenagers Serviced Each Year: 1,120 through counseling-Pregnant; 1,330 Parents through medical services; thousands through education.

The Somerville-Cambridge Teen Pregnancy Prevention Coalition was formed in response to the growing number of pregnant and parenting teenagers in the two communities. The communities recently received an award of $30,000 as a planning grant. Somerville and Cambridge haveboth developed high school programs: COPE-Comprehensive Parenting Education in Somerville High School and the Adolescent Parenting Program -APP in Cambridge Rindge and Latin High School. Four groups form the base of the Coalition: Needs Assessment, Outreach, Communications, and Program Development. Sue Hagedorn, Program Manager, 625-6600, ext. 2450.

44. Catholic Charitable Bureau Young Parents Program Contact Person:
324-6164

Services: Comprehensive counselling, crisis intervention, parenting training, general support program for young parents.
Funding Sources:
Number of Teenagers Serviced Each Year: 8 teenage clients

45. Chelsea Community Counselling Center Contact Person: Marion Dunk, Counselor
301 Broadway 889-3300
Chelsea, Ma. 02150

Services: Individual, group, family counselling in English or Spanish; sliding scale basis; young mothers support group; outreach; programs for teachers and parents; programs in schools.
Funding Sources:
Number of Teenagers Serviced Each Year: 35% of clients are children and teens. 2/3 white; 1/3 Hispanic.

46. Chelsea Memorial Health Clinic MGH
Adolescent Medical Service Contact Person: Kathleen Healey 884-8300
100 Bellingham Street
Chelsea, Ma. 02150
Prenatal Clinic Linda Richard 884-8300 ext. 385

Services: Adolescent and Pediatric Medicine Dept.: provides full medical care; free examinations for teens; pregnancy tests; lab. tests.
Mental Health Clinic: individual, group, family counselling for adults and children; pregnant teens; support groups for young parents at Chelsea High.
Prenatal Clinic: medical services to privately insured, uninsured, Healthy Start, Medicaid women; under auspices of St. Elizabeth's Hospital, offers a variety of low cost prenatal care and delivery options; transportation free to Hospital for tests, childbirth, emergencies; postnatal care.
Funding Sources: Adolescent and Pediatrics Dept.: Family Planning grant; federal Children and Youth funding; Prenatal Dept.: Medicaid, Healthy Start; WIC; Mental Health Clinic: sliding scale fees; Dept. of Health grant for support group at Chelsea High School; applications for hospital-provided free care, based on need.
Number of Teenagers Serviced Each Year:

47. Chelsea High School Contact Person: Denise Hurley
20 Crescent Ave. 889- 1129
Chelsea, Ma. 02150

Services: School nurse available to pregnant and parenting teens and encourages nutritional food; weekly nutrition class for pregnant students provided by Suffolk County Cooperative Extensions; vocational education; job placement, career training, counseling; work/study; encourages pregnant and parenting students to remain in school by offering support, flexible schedules, time for nutritional snacks, rests, or to nurse baby; intervention counselors; home tutoring.

HEALTH SERVICES: MASSACHUSETTS — HEALTH SERVICE AREA IV

Funding Sources:

Number of Teenagers Serviced Each Year:

48. Comprehensive Emergency Services
265 Beach St. Revere Community Counseling
Revere, Ma. 02151 Center
Contact Person: Shelley Baer
289-9331

Services: Emergency mental health services; variety of therapy; groups, including parenting group for teen parents; English, Spanish-groups.
Funding Sources: DSS for support group.
Number of Teenagers Serviced Each Year:

49. Employment Connections, Inc.
980 Broadway
Chelsea, Ma. 02150
Contact Person: Debra Hughes
884-1755

Services: Career Exploration program for teenage high school dropouts frequently serves young parents; GED preparation; ESL; employment counseling and referral and intensive skills training; training programs; special program for Pregnant and Parenting Youth begins in 1987.
Funding Sources: DPW ET site
Number of Teenagers Serviced Each Year:

50. Employment Resources, Inc. see #41

51. Iglesia de Dios
Contact Person:

Services: Family Training Hour; discussions of family issues
Funding Sources:
Number of Teenagers Serviced Each Year:

Housing: Chelsea has no specific housing programs for pregnant and parenting teenagers; housing agencies are listed in Action Plan.

52. MICAS
302 Broadway
Chelsea, Ma. 02150
Contact Person: Holly Lockwood
889-2760

Services: Casework with child abuse referrals; provides translation in selected situations; support groups for Asian young women at Chelsea High which focuses on acculturation issues including sexuality and drop out prevention; other programs.
Funding Sources:
Number of Teenagers Serviced Each Year:

North Suffolk Mental Health Association, Inc.
301 Broadway, Chelsea 02150, 889-4860
Bettie Kaitz, Associate Clinical Director

North Suffolk Mental Health Association has been appointed lead agency for the Chelsea Teen Pregnancy Coalition:Coalition has formed an Action Plan. Agencies have participated in work of coalition, and developed the Action Plan. Chelsea is one of the five "Commonwealth Future Cities" focusing on broad range of youth issues. Three Task Forces: Teen Pregnancy Prevention, Health and Social Services for pregnant/parenting teens, Education and Job Training; Coordinating Committee. Recommendations include case management services; training in sex education, communication skills, life planning for professionals, parents, teens; public awareness of services available; community support; cooperation with other groups; parenting education; abuse prevention; resources directory; resources and support for parents of teens; transition to independent living; increase availability of Spanish-speaking and Khmer staff at health and social service agencies.

Concord

53. Concord-Assabet Adolescent Services
Services to Youth Program
P.O. Box 114
Concord, Ma. 01742

Contact Person: Lisa Perry, M.A.
Program Coordinator
Stephen Joffee
Executive Director
263-1750, 369-2693

Services: No services specifically for pregnant and parenting teens; information counseling; referrals and information; library contains resources on sex education, birth control, pregnancy, abortion, adoption; diverse number of social, recreational, educational activities for teens; info. for youth's parents.
Funding Sources: Services to Youth only-Concord-Carlisle Community Chest; Town of Concord; private donations.
Number of Teenagers Serviced Each Year: Pregnant: 0 Parents: 1 or 2

54. Concord Area Early Intervention Program
Young Parents Program
Community Agencies Building
Concord, Ma. 01742

Contact Person: Carol Sheldon
Executive Director
369-3524

Services:

Funding Sources:

Number of Teenagers Serviced Each Year:

HEALTH SERVICES: MASSACHUSETTS — HEALTH SERVICE AREA IV

Dorchester

55. Aswalos House-YWCA
Comprehensive Adolescent Parenting Program
246 Seaver Street
Dorchester, Ma. 02121

Contact Person: Juanita Wade
Director
Bertha Woody, CAPP Dir.
442-9645

Services: Counseling: personal, educational, employment; workshops: parenting, life planning skills, family planning, health education, stress management, prenatal/postnatal care, decision-making, self-esteem, budgeting; support work: day care, transportation, social service advocacy, mentoring component; school education programs; home visits; medical visits; networking; tutorial program; career counseling; pregnancy prevention.
Funding Sources: DSS, Hyams Trust, United Way.
Number of Teenagers Serviced Each Year: Pregnant: 100 Parents: 150

56. Codman Square Health Center
6 Norfolk Street
Dorchester, Ma. 02124

Contact Person: William WalzcakExec. Dir.
825-9660

Services: OB-GYN; Pediatrics; social services; family planning; dentistry, mental health services; nutrition education; home visits for counseling by adolescent outreach worker; outreach community, schools; collaboratives.
Funding Sources: City of Boston, state, Boston Foundation, DSS, DCC.
Number of Teenagers Serviced Each Year: Pregnant: 60 Parents: approx. 200

57. Columbia Point Health Center
300 Mt. Vernon Street
Dorchester, Ma. 02124

Contact Person:
288-1140

Services: OB-GYN, Pediatrics, Family Planning, Midwifery, Infant and Toddler Unit-Day Care; Dental, mental health services, social services.
Funding Sources: Mixed.
Number of Teenagers Serviced Each Year: Greater number of parents than pregnant; unable to document exact number.

58. Dorchester House Multi-Service Center
Parent and Child Program
1353 Dorchester Ave.
Dorchester, Ma. -2122
MAPPS-CAHP, PPAP

Contact Person: Pamela Raab, Director
288-3230

Services: Home visits; developmental assessments by psychologist; individual and group counseling; parenting classes, workshops, field trips, special events; full range of health services; "grandmother's group" for parents of teen parents; outreach in schools and community; collaboratives; mental health services.
Funding Sources: DMH, DPH
Number of Teenagers Serviced Each Year: Pregnant: 30 Parents: 40

59. Harvard Street Neighborhood Health Center Contact Person: Georgia Simpson, Admin. Assistant
632 Blue Hill Avenue 825-3400
Dorchester, Ma. 02121
MAPPS - CAHP, PPAP
Services: Health education; emergency care services-walk-ins; 24 hour answering service; social work advocates available to assist in housing services; medical services: acute care for adolescents available; mental health-counseling services: four full time mental health workers available for acute and long-term care; nutrition counseling for prenatals, pediatric and adult medicine patients; family planning, including contraception; representatives of the TEE - Transitional Employment Enterprises- job training and placement program are available; networking and collaboratives.
Funding Sources: City of Boston Dept. of Health and Hospitals; DPH; health care coverage; family planning available at low, or no, cost.
Number of Teenagers Serviced Each Year; Pregnant; Parents:

60. Parent Child Center Contact Person: Linda Burke-Adams, Exec. Dir.
198 Geneva Avenue 288-5580
Dorchester, Ma. 02121

Services: Free daycare for teen parents who are in high school or GED programs; operate according to Boston Public Schools calendar; provide transportation in afternoons only for parent with child; work with most Boston Public High Schools; counseling, parenting sessions; work with parents of teens; networking and collaboratives with other agencies; community outreach.
Funding Sources: Federal government.
Number of Teenagers Serviced Each Year: Pregnant: 10 Parents: 25

61. Roxbury Children's Services Contact Person:
22 Elmhill Avenue 445-6655
Dorchester, Ma. 02122

Services: Outreach case management-counseling services to pregnant and parenting teens in Dorchester, Roxbury, Mattapan areas; groups for support services; activities organized to provide social peer interactions, and learning aspects of life outside teens own community; outreach in schools, community; individual counseling; 2 groups weekly for teen parents; family counseling; networking with local resources and city facilities; local businesses and church groups; advocacy, coordination of services; networking and collaboratives.
Funding Sources: DSS
Number of Teenagers Serviced Each Year: Pregnant: Parents:

62. Upham's Corner Health Center Contact Person:
500 Columbia Road 287-8000
Dorchester, Ma. 02125

Services: Primary medical care; lab. tests; family planning services; family health education seminars; childbirth classes; breast feeding classes; all classes available in English and Spanish; outreach in community-classes; parenting sessions; individual and family counseling; networking and collaboratives.
Funding Sources: Public-city, state, local; private funding.
Number of Teenagers Serviced Each Year: Pregnant: 75 Parents: 275 (1985 stats.)

63. Whittier Street Neighborhood Health Center Contact Person:
20 Whittier Street 427-1000
Dorchester, Ma.

Services: Adolescent Clinic; Young Parenting Program; Teen's Speakers Bureau; Teen Theatre Group; CDBG Adolescent Education, WIC counseling and social services; family planning and birth control services; Young Parent's Program: prenatal and postnatal care; nutritional counseling; pediatric care; individual counseling and advocacy; group meetings for friendship and education with other teen mothers and fathers; dental services; educational programs in schools, community-sexuality education, parent child communication, substance abuse, violence, etc.
Funding Sources: Title V, Title XX, ABCD Family planning; WIC, CDBG, Parenting Grant for Teens.
Number of Teenagers Serviced Each Year: Pregnant: 30 Parents: 50

Framingham

64. Framingham Youth Guidance Contact Person: Barbara Roderick
Teenage Pregnancy and Parenting Program Program Coordinator
88 Lincoln Street 235-5518
Framingham, Ma. 01701

Services: Counseling-individual, group, family; Education-parenting, life skills, childbirth; Outreach-home visits; Prevention-high school visits and consultation; Referral and advocacy; public speaking; counseling with parents of teens as needed.
Funding Sources: DSS, DMH, Junior League of Boston
Number of Teenagers Serviced Each Year: Pregnant: 10 Parents: 40

Hull

65. Hull Teen Clinic Contact Person: Rita Wood
180 Washington Boulevard 925-0671
Hull, Ma. 02045
Family Planning Services: A Program of
Health Care of Southeastern Mass., Inc.

Services: Gynecological examinations; pregnancy testing; birth control; community education; sexually transmitted diseases screening and referral; infertility information and referral; community education-parent-child communication, family life education, sexual decision-making, understanding adolescence, reproductive health.
Funding Sources: Sliding scale; Medicaid; no one denied services because of inability to pay.
Number of Teenagers Serviced Each Year:

Jamaica Plain

66. Brookside Community Health Center
Parent and Child Development Program
3297 Washington Street
Jamaica Plain, Ma. 02130
MAPPS - PPAP
Contact Person: Helene Stein
522-4700, ext. 221

Services: Young Families Clinic; health care; prenatal classes; mother/baby group; mother/toddler group; mental health services; infant assessment; advocacy and referral.
Funding Sources: DPH, DMH
Number of Teenagers Serviced Each Year: Pregnant; 13 Parents; 43

67. Comprehensive School Age Parenting Program
Jamaica Plain High School
Jamaica Plain, Ma. 02130
Contact Person; Todd Payton

Services: Provided to students in two high schools and one middle school; records kept on youth at two other middle schools; begun in 1978; parenting program is offered at English High School, J.P. High School and Grover Cleveland Middle School; students learn about prenatal care, graduate from school, find day care; programs collaborate with 20 hospitals and health centers; programs provide counseling in health care, nutrition, day care referrals, home tutoring, financial aid, employment and housing; weekly group meetings are held for new mothers and fathers; findings from studies: 165 young women received prenatal care and parenting counseling from area hospitals or through program; 32 boys at 2 high schools participate in parenting program; students ranged from 13-21 in grades 6-12; in 1986, of 197 students, 87 planned to return to school; 30 dropped out; 41 graduated; 12 transferred, 27 were uncertain of their school plans, had moved, or were enrolled in other programs.

68. Ecumenical Social Action Committee, Inc.
406 S. Huntington Avenue
Jamaica Plain, Ma. 02130
Contact Person: Robert Wooler
Executive Director
524-2555

Services: Counseling, advocacy, outreach and referrals; GED, career/vocational guidance; job placement, family meetings; collaboration with other providers, education/awareness workshops; tutoring; outreach and programs in local high schools; home visits; family work; preventive counseling; work with parents of teens.
Funding Sources: DSS, NDEA, Foundations, United Way, School Dept., Occ. Ed. Dept., MCCJ.
Number of Teenagers Serviced Each Year: Pregnant: 8-12 or more; Parents: 2-6

69. Martha Eliot Health Center
33 Bickford Street
Jamaica Plain, Ma. 02130

Contact Person: Robert Martin
Admin. Director
522-5300

MAPPS- CAHP

Services: Adolescent Clinic: range of services; medical care; drama groups; counseling; information and counseling on sexuality; gynecological examinations; contraceptive and pregnancy counseling; postnatal care; infant nutrition; Teen Father Program, operates in conjunction with Roxbury Parenting Project; counseling for depression, personal crisis, eating disorders; guidance for child abuse and family violence; suicide prevention; assistance for teens with learning disabilities or problems with school or employment; teen activity groups; pediatric department; Human Services Department; affiliate of Children's Hospital Medical Center; services are provided by bilingual staff; Young Parents.
Funding Sources: Children's Hospital; Healthy Start; DSS; DPH; Medicaid; insurance
Number of Teenagers Serviced Each Year: Pregnant: 35-40 deliveries Parents: 100-300 50 teen parents in Young Parent Program.

70. Southern Jamaica Plain Health Center
687 Centre Street
Jamaica Plain, Ma. 02130

Contact Person: Doreen Pollack-Twomey
522-5900

MAPPS- PPAP

Services: All pregnant teens assigned a caseworker, search for, and assistance with, obtaining necessary services; teens can be seen by social worker; nurse midwives; obstetrician; medical care; pregnancy testing; sexuality education programs; school and community outreach; family planning; individual, group, and family counseling; collaboratives with other agencies in coordinating teen educational programs.
Funding Sources:
Number of Teenagers Serviced Each Year: Pregnant: 20-25 Parents: 30-35

Lexington

71. RePlace, Inc.
1912 Mass Ave.
Lexington, Ma. 02173

Contact Person:
862-8130

Services: Confidential pregnancy testing; referrals for adoption; abortion information and services; decision-making counseling; weekly support group for pregnant and parenting teens; individual counseling; full time outreach worker; school, community outreach; group, family counseling; collaboratives; Y.M. group co-sponsored by Arlington Youth Consultation Center.
Funding Sources: State and local funds, with private donations from community.
Number of Teenagers Serviced Each Year: Pregnant: 5-10 Parents: 4-8

Marlboro

72. Health Information Referral Service
169 Pleasant Street, Box 449
Marlboro, Ma. 01752
Contact Person: 481-1960

MAPPS - CAHP
Services: Individual and family counseling; parenting; nutritional, prenatal, childbirth education; peer support groups; advocacy re: housing, medical care, education, employment training, daycare; GED tutoring; counseling and education in schools, community; work with parents of teens; collaboratives; Teen Health Clinic; Sexual abuse victim services-24 hour hotline; pregnancy testing; birth control counseling; information and referral.
Funding Sources: DSS, United Way, SDA Metro West
Number of Teenagers Serviced Each Year: Pregnant: 125 Parents: 75

73. Young Parents Program
same as above
sponsored by Health Information
Referral Service
Contact Person: Priscilla Caputo
Coordinator
481-1960

Services: Community and school-based programs; provides services to teens and their families in Marlboro, Northboro, Hudson, Southboro, Westboro; counseling, pregnancy testing; advocacy for help with medical, welfare, legal, educational and daycare needs; prenatal education; childbirth preparation; life management counseling; support groups combine activities and education to enhance pregnant care, parenting skills, child development, peer relationships, self-esteem; adoption counseling; health care assistance; drop-in center; tutoring and GED preparation; information and referral.
Funding Sources: DSS
Number of Teenagers Serviced Each Year:

Natick

74. Natick Recreation and Human Services Dept.
153 No. Main Street
Natick, Ma. 01760
Contact Person: Gwen Kermode
Ann Freeman
651-7267

Services: Short-term counseling; referral; family counseling; crisis intervention; outreach to schools, community; counseling-individual and family; group work; collaboratives with other providers, agencies, church groups; member of greater Framingham Youth Services Coalition; prevocational-Natick Community Farm; recreation programs.
Funding Sources: Town of Natick; fundraising.
Number of Teenagers Serviced Each Year: Pregnant: Parents:

Norwood

75. Norfolk Human Services, Inc.
150 Lenox Street
Norwood, Ma.

Contact Person: Ilene Weinberg, LCSW
769-8670
Young Mothers' Project

Services: Outreach, education; prenatal and postnatal care; child growth and development; effective parenting, working with community systems; advocacy, counseling, support through Mothers' Group, to improve parent/child interactions, to reduce stress and isolation; program is home-based; goal of Young Mothers' Project is to see that all young mothers have access to wide range of educational, health, and social services; use of services to help mothers make wise decisions about themselves and their babies.
Funding Sources: DMH, DSS
Number of Teenagers Serviced Each Year: Pregnant: 10 Parents: 25

Quincy

76. Quincy Teen Mothers Program
18 Spear Street
Quincy, Ma. 02169

Contact Person:
786-8704

Services: Academic program leading to diploma or GED; on-site nursery for students' babies; door-to-door transportation; weekly group and individual counseling; vocational testing; outreach and fcllow up; summer recreational program; outreach in schools, community.
Funding Sources: Quincy Public Schools; DMH, DSS, foundations, churches.
Number of Teenagers Serviced Each Year: Pregnant: 15 Parents: 15

77. Parent-Teen Talk
1354 Hancock Street
Quincy, Ma. 02169

Contact Person:
770-2460

Services: Talks given in schools, community, youth serving agencies, churches on South Shore; uses trained Teen Parents as educators; talks about obtaining information and skills; communication skills; variety of issues concerning teenagers, parents, families; topics; realities of teen pregnancy and teenparenthood, how to say no, responsible decision-making, peer pressures and sexual pressures, parent-child discussions; family and peer relationships
Funding Sources:
Number of Teenagers Serviced Each Year:

78. Quincy Family Planning
1354 Hancock Street
Room 205
Quincy, Ma. 02170

Contact Person:
770-2460

Services:

Funding Sources:

Number of Teenagers Serviced Each Year:

Roxbury

79. Dimock Community Health Center
55 Dimock Street
Roxbury, Ma. 02119

Contact Person: Jackie Jenkins-Scott
Executive Director
442-8802

Services: Alcohol program; educational training; placement and referral; dental program, medical program; health; vocational training program; outpatient program; mental health services.
Funding Sources: DSS, federal government; grants.
Number of Teenagers Serviced Each Year: 390 total adolescents

80. La Alianza Hispana, Inc.
409 Dudley Street
Roxbury, Ma. 02119

Contact Person; Luis Prado
Executive Director
426-7175

Services: Prevention education; community and school outreach; referrals; counseling and advocacy-families and individuals; social services-counseling to enable families and individuals to cope with personal, economic, domestic and other types of problems; families with low income problems and language barriers; motivation and support counseling; counseling to develop attitudes, communication skills, decision-making abilities; support for self-support and independent living; housing assistance; information and referral; adoption services; youth advocacy and counseling program
Funding Sources: DSS, DPH, JCS, United Way, MCHH, corporations, fundraising.
Number of Teenagers Serviced Each Year: Pregnant: 12 Parents: 10

81. Roxbury Area Planning Action Council
62 Warren St.
Roxbury, Ma. 02119

Contact Person: Georgette Leslie
Executive Director
442-5900

Services:

Funding Sources:
Number of Teenagers Serviced Each Year:

82. Roxbury Comprehensive Community Health Center, Inc.
435 Warren Street
Roxbury, Ma.

Contact Person: Carey Toran
Director of Planning
and Development

Services: Full range of primary Health Care services and ancillary services; services include acute and well check-ups, prenatal care, family planning, health education, etc.; have psychologist who specializes in adolescent mental health and a drug abuse counselor; community health worker; show educational videos; sessions on parenting issues; presentations in schools; Adolescent Clinic provides comprehensive health care for teens; pediatric care; prenatal care; nutrition counseling; pregnancy testing; WIC program; sex education, health education, birth control education; psychological services and assessments; short term individual and family therapy, group counseling and counseling of pregnant teens; parents of teens group; teen drop-in center; Parents Awareness Group; advocacy and outreach.

The Health Center and the Planned Parenthood League of Mass. have begun an innovative collaboration to develop a Teen Pregnancy Prevention Initiative (TPPI) in Boston. Goals of the program are: improve access to family planning medical services; provide sexuality education to targeted groups of youth, increasing self-image, responsible decision-making, career readiness, interest in life options; provide same services to teen parents to reduce repeat births; provision of wide range of comprehensive services; primary health care, reproductive health care; academic and vocational training; counseling and skill-building activities; encourage goal-setting; focus on positive alternatives to early childbearing.
Carey Toran is Director of Planning and Development; Nancy Drooker is Director of Education and Counseling of Planned Parenthood League.
Funding Sources: Dept. Health and Human Services, DPH, City of Boston, 3rd party, Medicaid, Hyams Trust, Boston Foundation; corporations.
Number of Teenagers Serviced Each Year: Pregnant: 20-40 Parents: 30-40

83. Urban League of Eastern Massachusetts
90 Warren Street
Roxbury, Ma. 02119
Contact Person: Elaine Gross
442-3123

Services:

Funding Sources;
Number of Teenagers Serviced Each Year:

Somerville

84. Family Center, Inc.
385 Highland Avenue
Somerville, Ma. 02144
Contact Person: Polly LaBrie
Executive Director
Anne Peretz
Director of Community and Professional Services
628-8815

85. Somerville Hospital, Division of Community Health
230 Highland Avenue
Somerville, Ma. 02143
Contact Person: Linda Cundiff
Director, Community Health Nursing
666-4400 ext. 106

Services; Individual and group counseling; casework management; prenatal/postpartum health care, pediatric care, WIC, referral to community services- GED VNA, etc.; Sex education in schools, grades 6-9; OB/Social Service case conferences; teen pregnancy group; sibling group; prenatal workshop; labor/delivery classes; family planning counseling; networking and collaboratives with other groups, agencies, providers.
Funding Sources: DPH-MIC; DSS-Family Planning and Counseling(Child Protection) Contracts; 3rd party payments.
Number of Teenagers Serviced Each Year: Pregnant: 75 Parents: 100+

86. Mary Ellen McCormick Health Center
10 Logan Way
South Boston, Ma.

Services: OB/GYN, Pediatrics, Family planning, midwifery; infant and toddler unit-day care; dental, mental health services, social services; sexuality education in schools.
Funding Sources: Mixed
Number of Teenagers Serviced Each Year:

Sudbury

87. Concerned United Birthparents
36 Dawson Drive
Sudbury, Ma. 01776
Contact Person: Libbi Campbell
Executive Director
443-3770

Services:

Funding Sources:
Number of Teenagers Serviced Each Year:

Waltham

88. Waltham Weston Hospital
Maternal and Child Health, Adolescent Clinic
Hope Avenue
Waltham, Ma. 02254
Contact Person:
647-6426

Services: Social Services; Nutrition; OB care; GYN; contraception; pediatrics; visiting nurse; individual, family, supportive counseling and psychotherapy; liaison with schools, DSS, community agencies, DPW; primary health care; family planning; VD testing; drug and alcohol information; pregnancy tests.
Funding Sources: Hospital subsidized.
Number of Teenagers Serviced Each Year: Pregnant: 30 Parents: difficult to estimate; pediatric clinic has many parents under 20 years.

Watertown

89. Watertown Health Center
85 Main St.
Watertown, Ma. 02172
Contact Person: Mary McCormick, RN
923-0001

Wellesley

90. Alliance for Children
110 Cedar St.
Wellesley, Ma. 02181
Contact Person: Filis Casey
Executive Director
431-7148

W. Newton

91. Newton Community Service Centers
Parent Aide Young Parent Program
492 Waltham St.
W. Newton, Ma. 02165
Contact Person: Tony Bibo
Executive Director
969-5906

Services: Weekly group counseling; individual counseling; crisis intervention; linkage with day care; educational programs; health services; outreach; match teens with appropriate parent aide-role model volunteer for 1 yr.; referrals; collaborativ
Funding Sources: United Way; Community Development Block Grant funds.
Number of Teenagers Serviced Each Year: Pregnant: 3-5 Parents: 10-14

SURVEY RECOMMENDATIONS HEALTH SERVICE AREA IV

A total of 40 surveys were received and analyzed from this area. The recommendations are as follows:

1. *60% of the responses stated that housing is needed. This includes subsidized housing, group care, and residential housing for teenagers. A few respondents added the need, under housing, for assistance in searching for, and finding, housing.

2. 47.5% stated that day care is needed. Some respondents stated that day care in general is needed, others stated that day care is needed in both schools, and in communities.

3. 40% stated that courses in parenting skills should be made available to parenting teenagers, and pregnant teenagers. Some specified that these courses should be located in the schools, others did not specify. A few stated that these courses should be mandated.

4. 27.5% stated that sexuality education programs are needed.

5. 22.5% stated that school-based health clinics are needed.

6. 22.5% stated that family planning and access to birth control services are needed.

7. 20% stated that job training and employment skills programs are needed.

8. 17.5% stated that transportation is needed-to services, day care; other transportation recommendations did not specify type of transportation.

9. 12.5% stated that funding for programs and services is needed.

10. Other recommendations fall into these categories:

    7.5% stated that programs focusing on teen fathers are needed.
    7.5% stated that increases in AFDC benefits are needed, and that benefits should be brought up to poverty level standards.
    7.5% stated that networking and coordination of services is needed.

11. 5% stated that Independent Living Programs are needed. These could be also included in housing needs. See Independent Living Programs under Social Services Programs.
    5% stated that Prevention Programs are needed. These did not specify type of prevention programs.
    5% stated that programs focusing on values are needed.

* A problem identified by service providers regarding housing needs is that Section 8 certificates for subsidized housing are not provided to teens who want to, or need to, share in group housing.

SURVEY RECOMMENDATIONS HEALTH SERVICE AREA IV

12. The following recommendations were stated one time each on the surveys:

family shelters
free information for teens who are pregnant, parenting, sexually active
continuing education opportunities
GED Preparation
Life Management Skills
Low cost prenatal care
Community-based, home based counseling for group activities
Babysitting
Peer Support Groups
providers who take Medicaid
counseling
medical care
Healthy Start funding
Mental Health and Social Services
dropout programs-prevention

HEALTH SERVICE AREA V*

*INCLUDES ACTIVE AND INACTIVE SUBAREA COUNCILS.

Cities and Towns in Massachusetts: Teenage Births: 1984-1985

Health Service Area 5: Total Teenage Births: 1984-1484 1985- 1460

	#Teen Births					
	12-17		18-19		Total Teen Births	
Cities/Towns	1984	1985	1984	1985	1984	1985
Abington	1	2	10	9	11	11
Acushnet	.1	3	5	7	6	10
Attleboro	8	19	28	38	36	57
Avon	0	6	1	2	1	8
Barnstable	6	10	12	26	18	36
Berkley	2	1	4	1	6	2
Bourne	2	6	4	17	6	23
Brewster	0	0	0	1	0	1
Bridgewater	2	10	6	5	8	15
Brockton	28	89	118	153	146	242
Carver	1	3	2	2	3	5
Chatham	0	0	2	1	2	1
Chilmark	0	0	0	0	0	0
Dartmouth	4	8	7	15	11	23
Dennis	0	3	10	10	10	13
Dighton	2	1	1	4	3	5
Duxbury	1	0	2	1	3	1
E. Bridgewater	0	3	6	5	6	8
Eastham	1	0	0	0	1	0
Easton	0	5	2	2	2	7
Egartown	0	1	0	1	0	2
Fall-haven	2	8	10	15	12	23
Fall River	29	74	114	166	143	240
Falmouth	12	4	25	23	37	27
Freetown	2	2	3	4	5	6
Gay Head	0	0	0	0	0	0
Gosnold	0	0	0	0	0	0
Halifax	1	4	5	2	6	6
Hanover	1	1	4	1	5	2
Hanson	4	1	3	8	7	9
Harwich	0	2	1	3	1	5
Kingston	2	1	1	3	3	4
Lakeville	2	2	2	6	4	8
Mansfield	1	3	12	7	13	10
Marion	1	0	2	0	3	0
Marshfield	0	6	3	8	3	14
Mashpee	0	3	3	3	3	6
Mattapoisett	0	2	5	5	5	7
Middleborough	4	8	13	19	17	27
Nantucket	0	2	1	3	1	5
New Bedford	31	81	112	142	143	223
No. Attleboro	1	14	11	18	12	32
Norton	3	5	5	11	8	16
Oak Bluffs	0	0	2	3	2	3
Orleans	0	0	0	4	0	4
Pembroke	1	3	3	4	4	7
Plainville	1	4	4	7	5	11
Plymouth	2	9	11	36	13	45
Plympton	0	0	1	1	1	1
Provincetown	0	0	0	0	0	0

Cities and Towns in Massachusetts, 1984-1985

City/Town	#Teen Births 12-17 1984	12-17 1985	18-19 1984	18-19 1985	Total Teen Births 1984	Total Teen Births 1985
Raynham	3	4	1	5	4	9
Rehoboth	0	1	3	3	3	4
Rochester	1	1	0	0	1	1
Rockland	1	9	14	13	15	21
Sandwich	0	0	2	4	2	4
Seekonk	0	3	0	2	0	5
Somerset	2	3	4	7	6	10
Stoughton	4	5	8	11	12	16
Swansea	4	8	3	5	7	13
Taunton	14	29	41	48	55	77
Tisbury	0	1	0	3	0	4
Truro	0	0	1	0	1	0
Wareham	5	8	19	24	24	32
Wellfleet	0	0	1	0	1	0
W. Bridgewater	2	2	6	2	8	4
W. Tisbury	0	0	0	0	0	0
Westport	3	12	12	11	15	23
Whitman	2	5	8	9	10	14
Yarmouth	3	4	8	8	11	12

Abington

1. Health Care of Southeastern Mass., Inc. Contact Person:
   728 Brockton Aven 588-0141
   Abington, Ma. 02351
   MAPPS - PPAP

Services: Family planning; GYN services; parenting advocacy; court advocacy; counseling; medical care, WIC nutrition; options counseling and referrals; outreach-preventive education; individual, group, family counseling; work with parents of teens; collaboratives; comprehensive family health; social services; services to young parents; prenatal care; Parent-Teen Talk program; community health education; 15 locations in area, serve adjacent communities: Attleboro, Brockton, Bourne, Fall River, Falmouth, Hull, Hyannis, Martha's Vineyard, Nantucket, New Bedford, Quincy, Plymouth, Provincetown, Taunton, Wareham.
Funding Sources: U.S. Dept. of Health and Human Services; Federal Emergency Management Agency, U.S. Dept. of Agriculture; Mass. DSS, DPH, DPW, DYS, DMH; City of Brockton, Towns of Avon, Bridgewater, Old Colony United Way, Kelley Foundation, Anderson Foundation, N.E. Telephone.
Number of Teenagers Serviced Each Year: Pregnant: approx. 3,000 Parents: 400

Attleboro

2. Attleboro Area Youth and Family Services, Inc.
   Young Parents Program Contact Person:
   Box 2037, 247 Maple Street 226-5378
   Attleboro, Ma. 02703

Services: Individual, family, couple counseling; support/education groups meet weekly; information and referral; short-term counseling; advocacy and outreach; home visits; transportation; prenatal health instruction; child-birth preparation classes; postpartum home visits; community education for parents, teens, high school teachers on issues on adolescent parenthood; maintain office at Attleboro High School; crisis intervention; work with parents of teens-group and individual counseling; collaboratives and networks; case management.
Funding Sources: DSS, United Way of Northern Bristol County.
Number of Teenagers Serviced Each Year: Pregnant/Parenting: 269-105 open cases last year: 7/1/85-6/30/86.

3. Catholic Social Services Contact Person:
   10 Maple Street 226-4780
   Attleboro, Ma. 02703

Services: Adoption services; individual, marital, family counseling; unmarried parents' supportive services; foster care of newborns; information and referral social services counseling; ongoing counseling during and after pregnancy; exploring various options with emphasis on individual decision making; support in arranging medical, financial, legal services; help in obtaining living arrangements; temporary foster care for infant while decision is being made.
Funding Sources: Catholic Charities Appeal
Number of Teenagers Serviced Each Year:

HEALTH SERVICES: MASSACHUSETTS — HEALTH SERVICE AREA V

4. Family Planning of Attleboro
95 Pine Street
Attleboro, Ma. 02703
Contact Person: Lynda Lewis, Program Director
226-1586

Services: Counseling and referrals; pregnancy testing; postnatal check-ups and GYN care; Community Health Education -provides sessions to parents, teens, professionals, church groups, etc. on communication, decision-making, health care, birth control, etc.; groups done by outreach and by requests.
Funding Sources: Federal and state
Number of Teenagers Serviced Each Year: Total active caseload: 1100-not all pregnant or parenting.

5. Office for Children
7 North Main Street
Attleboro, Ma. 02703
Contact Person:
226-2336, 727-8948

Services: Help for Children; information and referral, follow-up and individual case advocacy; case coordination on a short-term basis when agency/agencies of primary responsibility has not been identified; follow-up to insure services are being provided accordingly-all services pertaining to children and their families; public speaking; general education; interview pregnant and parenting teens to access services; collaboratives; case conferences and case presentations; request assistance for basic needs.
Funding Sources: State.
Number of Teenagers Serviced Each Year:

Brockton

6. Birthright of Greater Brockton
646 Centre Street
Box 1082
Brockton, Ma. 02402
Contact Person: Mary Bochek, Co-Director
583-1510

Services: Volunteer service providing free pregnancy tests and non-professional "friendship" counseling; supply those in need withmaternity clothes, baby clothes, baby furniture; if desired, client can have a "Birthright Friend" who remains in contact with her throughout pregnancy; information and referral; individual and group counseling.
Funding Sources: Private donations
Number of Teenagers Serviced Each Year: Pregnant; approx. 400

7. Brockton Children and Youth Project/Brockton Hospital
680 Centre Street
Brockton, Ma. 02402
Contact Person:
583-2900

Services: Provide primary health care services to medically indigent, 0-18 years of age; pregnant teenagers are referred to medical services in Boston or to local OB-GYN practices.
Funding Sources: DPH, hospital in-kind, monies reimbursed for services rendered.
Number of Teenagers Serviced Each Year:

HEALTH SERVICES: MASSACHUSETTS HEALTH SERVICE AREA V

8. Brockton Visiting Nurse Association Contact Person:
300 Battle Street 587-2121
Brockton, Ma. 02401

Services: Skilled nursing visits in home for prenatal, postpartum, family planning, pediatric assessment; teaching, counseling, advocacy; MCH specialist/ pediatric nurse practitioners; medical social worker for high risk maternal-child population; parent aides; parenting skills teaching; network closely in schools; work practicum for high risk teens in school; counseling; collaboratives; work with parents of teens.
Funding Sources: MCD, 3rd party, DSS, DPH(high risk infant); United Way; Healtny Start.
Number of Teenagers Serviced Each Year: Pregnant: 300 est. Parents: over 6,000 visits in 1 year-nursing only.

9. Catholic Charities Centre Contact Person:
686 North Main Street 587-0815
Brockton, Ma. 02401

Services: Decision-making counseling around unplanned pregnancies; ongoing counseling following birth of baby around post-surrender, parenting and personal issues; temporary foster care; adoption services; parenting support group; decision-making groups; speaking in community, groups, schools, as requested; mental health clinic; adolescent independent living; collaboratives.
Funding Sources: DSS, minimal funding from client fees.
Number of Teenagers Serviced Each Year: 104 pregnant and/or parenting

Fall River
10. Citizens for Citizens Family Planning Contact Person:
337 Hanover Street 679-0198
Fall River, Ma. 02720

Services: Women's Health-contraceptive exams; pregnancy tests; social service or other referrals; screening for STD if indicated; Fall River and TAunton have 24 hour answering service; education; parenting, preventive reproductive health; outreach in community, schools; groups-parents and teens; collaboratives; in Taunton, work as team member inpregnant and parenting programs to offer health issues approaches to teens; networks; family planning services.
Funding Sources: Dept. Health and Human Services; DSS; Fees.
Number of Teenagers Serviced Each Year: Pregnant: 934 teens under 18 come in for pregnancy tests-estimate 25% on first visit; referrals for appropriate services; can't identify parents.

11. Fall River Pregnant and Parenting Teen Coalition

Contact Person: Rose Lobo Fernandes
Consultant
Suzanne Black, OFC

HEALTH SERVICES: MASSACHUSETTS HEALTH SERVICE AREA V

Formed in June, 1986; comprised of 82 members from various social agencies, religious groups, education, public health, maternal health, consumer groups housing authority, local hospitals and clinics, employment training agencies and obstetrical and pediatric services in Greater Fall River Area. Coalitions formed under direction of Governor's Office on Women's Issues in conjunction with Dept. of Public Health. Three main goals: prevention of teenage pregnancy, helping pregnant teens to access health care services for themselves and their children, helping young parents complete high school and become economically self-sufficient. Three core groups addressed three main goals; Executive Committee reviewed recommendations from core groups, formulated a coordinated Action Plan and developed plans for the continuation of the coalition. Recommendations of the coalition are stated at the end of this section's recommendations.

12. Family Planning of Fall River — Contact Person: Betty Borden
    1820 Highland Avenue
    Fall River, Ma. 02720

Services:

Funding Sources:
Number of Teenagers Serviced Each Year:

Falmouth

13. Early Child Bearing Program: Health Care of Southeastern Mass. — Contact Person: Michelle Burns, Coordinator, 548-0411
    314 Gifford Street Unit#1 Homeport
    Falmouth, Ma. 02541 MAPPS- PPAP

    Services: Home visits by Community Health Nurse from time of pregnancy identification through child's second birthday; peer support groups; referral help with finances, housing, education, child care; coordination and consultation with community resources; individual and family counseling in times of crisis; prevent infant mortality and morbidity; help resolve family crises that often follow teen pregnancy; service areas: Falmouth, Mashpee, Bourne; work with schools.
    Funding Sources: DPH, March of Dimes.
    Number of Teenagers Serviced Each Year: Pregnant: 40 Parents: 80-100

Hyannis

14. Center for Individual and Family Services — Contact Person: Linda Whittlesey, Family Therapist, 775-1859
    460 West Main Street
    Hyannis, Ma. 02601
    Adolescent Parents Program

    Services: Counseling-teen, her family, father of child; casework to get AFDC, medical care, housing, WIC, including information and referral; career and educational counseling to get into GED, job training or continue high school; adoption counseling during and after pregnancy; Lamaze; childbirth education classes; mother's parenting skills; support groups; work with parents of teens; member of RAPP-Resources to Adolescents for Pregnancy and Parenting.
    Funding Sources: DSS
    Number of Teenagers Serviced Each Year: Pregnant: 20 Parents: 20

HEALTH SERVICES: MASSACHUSETTS HEALTH SERVICE AREA V

Satellite Offices: 81 Old Colony Way, Box 340, Orleans, Ma. 02653, 255-2981; 293 Commercial Street, Provincetown, Ma. 02657, 487-2031.

15. Center for Individual and Family Services Contact Person: Linda Whittesley
78 Pleasant Street
Hyannis, Ma. 02601
Young Parents Program

Services: Information and referral services for medical care, financial and housing assistance; educational/vocational planning; WIC; counseling at home regarding decision-making process; available alternatives; family, couple or individual counseling throughout pregnancy and postpartum periods; support and education.
Funding Sources: DSS, United Way
Number of Teenagers Serviced Each Year:

16. Cape Cod Mental Health Associates Contact Person:
78 Pleasant Street
Hyannis, Ma. 01601

Services:

Funding Sources:
Number of Teenagers Serviced Each Year:

17. RAPP Contact Person:
Resources for Adolescent Pregnancy and Parenting
Box 786
Hyannis, Ma. 02601

Services:

Funding Sources:
Number of Teenagers Serviced Each Year:

New Bedford

18. New Bedford Child and Family Services Contact Person:
1061 Pleasant Street 996-8572
New Bedford, Ma.

Services: Case management; counseling-individual, group; health education; advocacy groups; tutoring for GED; tutoring for school credit; child care; health services; housing; parenting groups; work in schools, community; crisis intervention; work with familiesof teens; collaboratives-Greater New Bedford Community Health Center, N.B. School Dept., OFC.

HEALTH SERVICES: MASSACHUSETTS HEALTH SERVICE AREA V

Funding Sources: DSS, Action, Fees, United Way
Number of Teenagers Serviced Each Year: Pregnant: 150 Parents: 200

19. New Bedford Child and Family Service Young Parents Initiative Policy offers health, educational, and social service resources to expectant and parenting adolescent mothers and fathers and their families in the areas of New Bedford and Fall River. The New Bedford area service is a coalition of four local providers: New Bedford Child and Family Service, Office for Children, Greater New Bedford Community Health Center, New Bedford public schools. Basic services individual and family counseling for both expectant parents and their extended families; counseling provided in home; alternatives to unplanned pregnancy; are explored, including parenting, temporary infant foster care, adoption; weekly health and education and parenting education groups and individually; School Dept. offers GED tutoring and alternative school credit junior and senior high school education at an alternative school site; community advocate; independent living skills. Fall River service offers health, educational, and social service resources from office location; basic services: (same as above) and GED tutoring and on-site child care offered at office location

20. New Bedford Women's Center, Inc. Contact Person:
252 County Street
New Bedford, Ma.

Services:

Funding Sources:

Number of Teenagers Serviced Each Year:

Orleans

21. Cape Cod Family and Children's Services
P.O. Box 340
Orleans, Ma. 02653
(See #14.

Plymouth

22. Young Parents Program Contact Person:
Early Childbearing Program 746-0215
Plymouth Community Nurse Association
22 Summer Street
Plymouth, Ma. 02360

Services: Individual home visits by nurse and/or social worker for pregnant and parenting teens under age 23; prenatal education and information; parenting education; decision-making; supportive counseling; referralsto community agencies; birth control information; childbirth preparation classes-6 week sessions free of charge; outreach provided at local physician's office; outreach in local schools. Early Childbearing Program provides nursing and social services to teenagers during pregnancy and through at least one year post delivery; offers education and supportive services to parenting teens; work with local physicians, schools and service providers.
Funding Sources: DSS
Number of Teenagers Serviced Each Year: 150 Teenagers each year.

HEALTH SERVICES: MASSACHUSETTS — HEALTH SERVICE AREA V

Taunton

23. DARE Family Services
189 Dean Street
Taunton, Ma. 02780

Contact Person: Janice Lowery-Spark
824-6606
Teen Parent Program Supervisor

Services: Information/referral; individual counseling-primarily home visits; and school-based; support groups-including parent ed/peer relations; outreach/ advocacy/community education; service coordination; transportation; outreach programs in community; guest speakers, facilitators, social services to day care in schools; work with parents of teens through home visits; collaboratives-leadership in Taunton Area Teen Parent Collaborative.
Funding Sources: DSS
Number of Teenagers Serviced Each Year: Pregnant: 15-20 Parents: 30-40 started waiting list

24. Health Care of Southeastern Massachusetts
Early Childbearing Program
19 Spring Street
Taunton, Ma. 02780

Contact Person: Kathleen O'Donnell
Program Coordinator
822-7700

MAPPS - PPAP
Services: To provide a healthy birth experience for teens and their babies, prevention of infant mortality and morbidity; resolution of family crises; home visits from time of pregnancy identification through child's second birthday; peer support groups; referral help with finances, housing, education; coordination and consultation with community resources; collaboratives.
Funding Sources: DPH
Number of Teenagers Serviced Each Year: Pregnant: 30 Parents: 60

25. Visiting Nurse Association
Hubbard House
14 Church Green
Taunton, Ma. 02780

Contact Person:

Services:

Funding Sources:
Number of Teenagers Serviced Each Year:

SURVEY RECOMMENDATIONS HEALTH SERVICE AREA V

A total of 19 surveys were received and analyzed from this area. A few surveys were recently sent to service providers and agencies in this area. These results will be added to the study when they are returned. The recommendations are as follows:

1. 53% of the responses stated that prevention programs are needed. Some stated that funding was needed for these programs. Others stated that prevention programs are needed in schools to prevent teen pregnancy and early childbearing; to prevent dropping out and target those teens who experience poor attendance, and younger teenagers.

2. 53% stated that child care/day care programs are needed. Some specified that these programs are needed in high school locations.

3. 40% stated that school-based clinics are needed. Some stated that such programs must be comprehensive in scope.

4. 26.6% stated that family life education, health education, sexuality education programs are needed. Some responses stated that these programs should be mandated. Others specified that funding for education programs is needed.

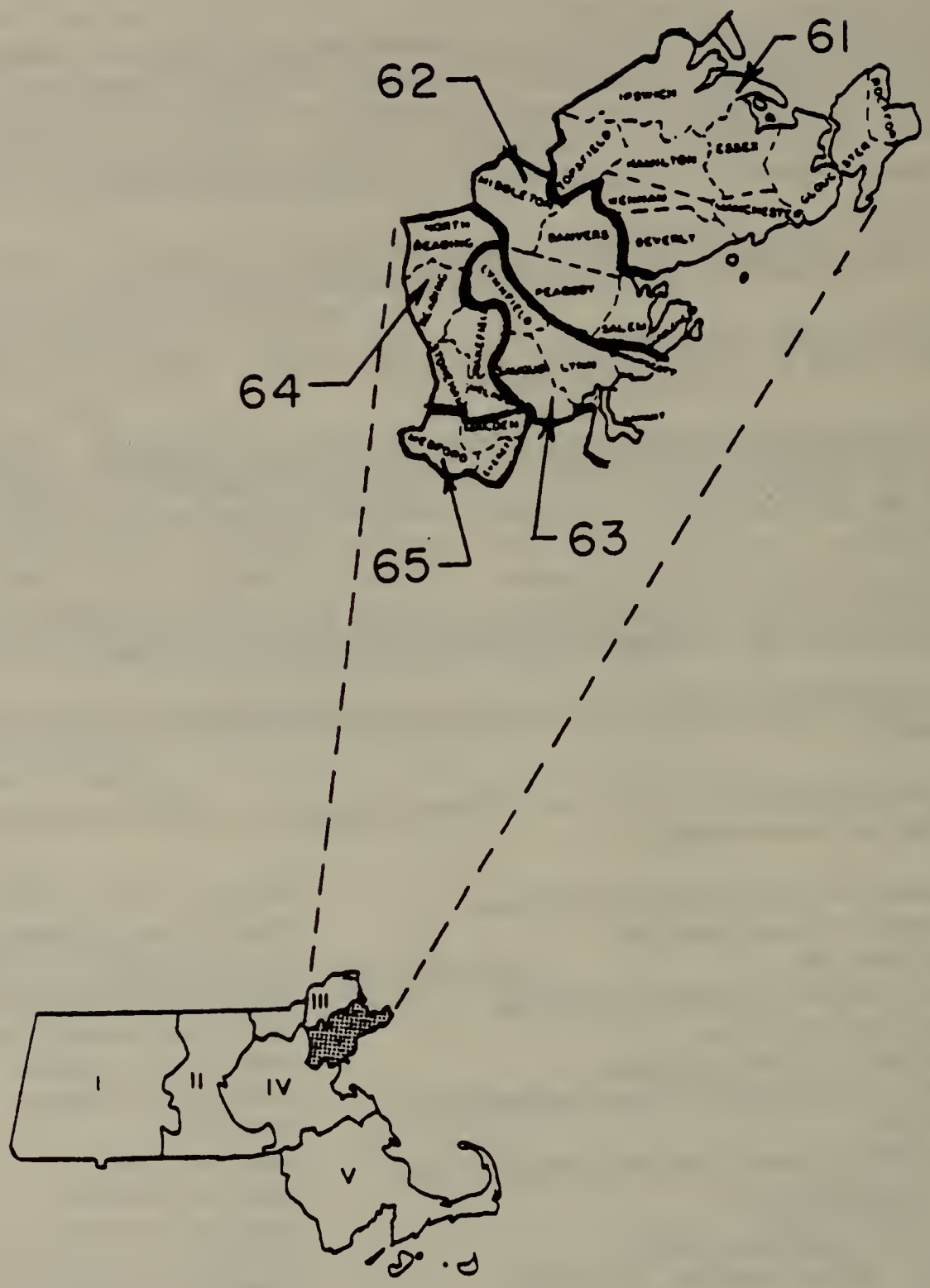
5. 26.6% stated that transportation services are needed. Some specified transportation to day care and/or other services is needed.

6. 13.3% stated that job skills training and employment training programs are needed.

7. Other recommendations fall into these categories: the following appeared one time on the surveys:

comprehensive residential programs
state agency coordination
24 hour hotline
improved family planning services
life options programs
independent living programs
improved coordination/less fragmentation of services
elimination of overlapping jurisdiction in service delivery
support services
funding for prenatal care
3rd party reimbursement for MSW's
more MSW's
gradual reduction of welfare benefits as clients begin work, including medicaid and food stamps
women's services
individual counseling
outreach
multidisciplinary clinics
adoption counseling
for young mothers
parenting classes, with school credit
home visits
health courses
funding for all programs
funding at central level
flexible school schedule
flexible curriculum requirements

HEALTH SERVICE AREA VI



Cities and Towns in Massachusetts: Teenage Births 1984-1985

Health Service Area 6: Total Teen Births: 1984-491 1985-473

City/Town	# Teen Births 12-17 1984	12-17 1985	18-19 1984	18-19 1985	Total Teen Births 1984	Total Teen Births 1985
Beverly	4	9	13	19	17	28
Danvers	2	7	8	8	10	15
Essex	0	0	1	0	1	0
Everett	0	9	19	21	19	30
Gloucester	1	8	16	17	17	25
Hamilton	0	0	1	0	1	0
Ipswich	0	2	3	7	3	9
Lynn	38	60	66	113	104	173
Lynnfield	0	0	2	0	2	0
Malden	2	12	21	18	23	30
Manchester	0	0	0	0	0	0
Marblehead	0	1	0	1	0	2
Medford	3	14	17	19	20	33
Melrose	1	0	4	7	5	7
Middleton	2	0	2	2	4	2
Nahant	0	0	0	0	0	0
North Reading	0	3	1	5	1	8
Peabody	3	7	17	23	20	30
Reading	0	4	3	6	3	10
Rockport	0	2	2	0	2	2
Salem	9	13	23	26	32	39
Saugus	1	4	4	6	5	10
Stoneham	0	3	6	5	6	8
Swampscott	0	1	3	3	3	4
Topsfield	0	0	1	1	1	1
Wakefield	0	3	5	3	5	6
Wenham	0	0	0	1	0	1

HEALTH SERVICES; MASSACHUSETTS — HEALTH SERVICE AREA VI

Beverly

1. HealthQuarters, Inc.
19 Broadway
Beverly, Ma. 01915

Contact Person; Claire Gordon
Executive Director
927-9824

Services: (Formerly North Shore Regional Family Planning Council, Inc.) Gyn Services to approximately 3500 teenagers; counseling, pregnancy testing; family planning; education sessions; education classes, workshops, lectures; work with schools, church groups; community groups; reproductive health needs; physical exams.; contraceptive information and counseling; prenatal counseling; adoption counseling and referral; abortion referral and post-abortion checkups; diagnosis, treatment, counseling for sexually transmitted diseases; other medical screening and testing; adolescent and parent counseling.
Funding Sources: Dept. Health and Human Services; DSS; DPW-Medicaid; private grants, sliding fee scale.
Number of Teenagers Serviced Each Year: 3500 teenagers

2. Project RAP
9 Highland Ave.
Beverly, Ma. 01915

Contact Person: 927-4506

Services: Crisis Intervention; 24 hour hotline; drop-in center; walk-in counseling; mobile crisis team; outreach to persons in need of mental health intervention; pregnancy screening/options counseling; rape and sexual assault intervention-24 hour response to victims of rape and sexual assault; medical and legal advocacy; education and training; counseling for substance abuse; individual, group and family counseling; school-based group counseling for adolescents; corrections counseling; B.A.S.I.C.S.-Building Alternative Skills for Interpersonal Communication and Survival; Young Parent Program-comprehensive services for pregnant teens and teen-age parents and their children-in affiliation with North Shore Children's Hospital; Project EXTRA-adventure-based counseling in after school and weekend programming; temporary shelter for youth; displaced homemakers program; peer education; volunteer training and supervision; community education. Serves as multiservice, community-based agency to Beverly, Danvers, Salem, Peabody, Middleton, Marblehead, Wenham, Hamilton, Topsfield, Essex, Ipswich, Gloucester, Rockport, Manchester, Magnolia.
Funding Sources: Dept. Mental Health, Dept. Public Health, Dept. Public Welfare, Dept. Social Services; fees, fundraising, United Way; volunteer; city/town funding.

Gloucester

3. Action
23 Elm Street
Gloucester, Ma.

Contact Person: 283-7874

Services; Provides services for independent living, counseling, food, shelter, living quarters, welfare services.
Funding Sources:
Number of Teenagers Serviced Each Year:

4. Birthright of Cape Ann
123 Main St.
Gloucester, Ma. 01930
Contact Person; Tom Griffith
281-4199

Services: Free pregnancy tests; counseling aimed at discouraging abortion; maternity clothes; baby clothes and furniture; referrals to social service agencies; follow-up counseling; presentations at schools and churches; helps with community resources for financial, emotional, legal, medical help.
Funding Sources: Individual donors, some local churches; one Boston Foundation.
Number of Teenagers Serviced Each Year: Pregnant: approx. 20 Parents: approx. 30

5. Child Development Programs of Cape Ann, Inc.
120 Maplewood Ave.
Gloucester, Ma. 01970
Contact Person: John Root, Director of Social Services
281-2400

Services: Provides family day care to enable parents to work, receive education or training; protective service day care referred by DSS; parenting support group; Headstart, Project Image, WIC.
Funding Sources; DSS; U.S.D.A.; Dept. Health and Human Services.

6. New England Christian Action Counsel
11 Pleasant St.
Gloucester, Ma. 01970
Contact Person: John C. Rankin
Executive Director
283-4575

Services: Pro-life activist ministry; small part interfaces with teen pregnancy; Crisis Pregnancy Centers in Cambridge, Haverhill, Leominster, Springfield - deal with teen pregnancy frequently; operate independently; counseling for PAS-post-abortion syndrome; collaboratives-referral clearinghouse-homes for unwed mothers and advocacy.
Funding Sources: Individuals, churches.
Number of Teenagers Serviced Each Year: less than 12

7. North Shore Catholic Charities Centre
60 Prospect Street
Gloucester, Ma. 01930
Contact Person:
283-2019

Services: Comprehensive range of services to pregnant and parenting teens regardless of income level, race or creed, including: assessment; individual/couple/family counseling; group treatment for teen and young adult parents; day care; crisis intervention and outreach; foster care and adoption services; emergency economic and advocacy assistance including food bank, financial assistance, clothing assistance, housing advocacy, referral and advocacy for educational, job, legal, and medical services. The agency is beginning to look into a subsidized housing project specifically geared to young single parents. Program has close affiliation with an R.N., who offers teen prenatal and birthing classes; referrals for GED; hospital referrals and emergency response for prenatal, birth referrals; close cross-referral within agency to day care, emergency assistance, family counseling, protective program; outreach education.
Funding Sources: DSS/Cape Ann and Danvers/Salem area; United Way; agency subsidy through private fundraising.
Number of Teenagers Serviced Each Year: Pregnant: Parents: 60-70

8. NUVA, Inc.-Huntress Home
3 Emerson Avenue
Gloucester, Ma. 01930
Contact Person:
283-2911

Services: Services provided to all women who reside at the Huntress: food and shelter, individual, couple, family therapy; parenting skills group; relationship group; budget management skills training; housekeeping skills; community outreach-relationship group open to public; family life education, job training, self-concept, esteem building; family planning activities; sex education; homes and shelters for pregnant adolescents; pregnancy testing, nutrition counseling, WIC.
Funding Sources: Public and private; DPW; private donations.
Number of Teenagers Serviced Each Year:

9. Wellspring
302 Essex Avenue
Gloucester, Ma. 01930
Contact Person:
281-3221

Services: Pregnancy prevention and life planning for teens and parents of teens; counseling; crisis center for homeless teens; sex education; sex counseling; contraceptive information and distribution; shelter for homeless adolescent and child; health services.
Funding Sources:
Number of Teenagers Serviced Each Year;

10. YMCA
71 Middle Street
Gloucester, Ma. 01970
Contact Person:
283-0470

Services: Recreational activities for teens; clubs; athletic teams; self-concept/self esteem building; leadership training
Funding Sources:
Number of Teenagers Serviced Each Year:

Cayte Ward is Director of the Cape Ann Teen Pregnancy Task Force. The Task Force has issued a position paper, and outlined its goals: expand membership base of the task force; develop information on service and program needs of teens; information-sharing; comprehensive teen network referral service; needs assessments; establish a coalition of interested parties to centralize and coordinate teen health, pregnancy, and parenting services and programs; search funding sources; develop a range of services for this population

HEALTH SERVICES: MASSACHUSETTS — HEALTH SERVICE AREA VI

Lynn

11. Catholic Family Services
55 Lynn Shore Drive
Lynn, Ma. 01902

Contact Person: Virginia O'Connell
Director, Services
to Young Families
593-2312

Services: Individual counseling; group, family and couples counseling; foster care and adoptive services; prenatal classes; outreach and advocacy services; community education and training; vocational development; follow-up program projected for near future; education and training for variety of community groups; education and training for students and teachers; parenting sessions; at-home services; transportation to bring clients to agency; collaboratives.
Second Chance School: Alternative School for pregnant teenagers in Lynn; also new Transitional Housing Program: young single parents mothers
Project Prepare: Help with medical care; help with job-finding, welfare and Medicaid, nutrition, adoption counseling, family day care to help while in school or at work

Funding Sources: DSS; United Way
Number of Teenagers Serviced Each Year: Pregnant: Approximately 150-175 pregnant and parenting teenagers and young parents.

12. Lynn Community Health Center
86 Lafayette Park
Lynn, Ma. 01902

Contact Person: Stephen Price
Director
581-3900

Services: counseling, health education, prenatal care, family planning, nutrition, WIC program; pediatrics
Funding Sources: Federal, WIC, county, CHC, DPH
Number of Teenagers Serviced Each Year: Pregnant; 33 Parents:

13. The Salvation Army
1 Franklin Street
P.O. Box 847
Lynn, Ma. 01903-1047

Contact Person: Robert G. Miga, Captain
Corps Commanding Officer

Services: Program under the auspices of the Salvation Army is the Teenage Parenting and Pregnancy Program (T.A.P.P.) designed to assist young parents in becoming economically independent of the welfare system; program enables clients to accomplish this goal through job training, GED completion, college education, and emotional group support; provides variety of services to help clients complete their goals-transportation, to daycare, etc., community advocacy; counseling and educational and job training assistance; referrals to financial assistance, shelter, emergency assistance; family planning; recreation; support groups; nutrition counseling; home visits.

Funding Sources: North Shore Employment Training

Lynn Teen Pregnancy Coalition; Northeast Health Planning Council, Inc. 29 Lowell St., Peabody, Ma. 01960, Executive Director-Ed Marakovitz; Coalition has issued an interim report; co-convenors are Girls' Club, Office of Mayor, Salva Army, Lynn Community Health Center, Northshore Employment Training, Health Planning of the North Shore and Merrimack Valley; address specific needs of pregnant and parenting teens; form referral, coordinated service networks; plan to compile a

Lynn

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55 Lynn Shore Drive
Lynn, Ma. 01902

Contact Person: Virginia O'Connell
Director, Services
to Young Families
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Services: Individual counseling; group, family and couples counseling; foster care and adoptive services; prenatal classes; outreach and advocacy services; community education and training; vocational development; follow-up program projected for near future; education and training for variety of community groups; education and training for students and teachers; parenting sessions; at-home services; transportation to bring clients to agency; collaboratives.
Second Chance School: Alternative School for pregnant teenagers in Lynn; also new mothers
Transitional Housing Program: young single parents
Project Prepare: Help with medical care; help with job-finding, welfare and Medicaid, nutrition, adoption counseling, family day care to help while in school or at work

Funding Sources: DSS; United Way
Number of Teenagers Serviced Each Year: Pregnant: Approximately 150-175 pregnant and parenting teenagers and young parents.

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Funding Sources: Federal, WIC, county, CHC, DPH
Number of Teenagers Serviced Each Year: Pregnant: 33 Parents:

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Services: Program under the auspices of the Salvation Army is the Teenage Parenting and Pregnancy Program (T.A.P.P.) designed to assist young parents in becoming economically independent of the welfare system; program enables clients to accomplish this goal through job training, GED completion, college education, and emotional group support; provides variety of services to help clients complete their goals-transportation, to daycare, etc., community advocacy; counseling and educational and job training assistance; referrals to financial assistance, shelter, emergency assistance; family planning; recreation; support groups; nutrition counseling; home visits.

Funding Sources: North Shore Employment Training

Lynn Teen Pregnancy Coalition; Northeast Health Planning Council, Inc. 29 Lowell St., Peabody, Ma. 01960, Executive Director-Ed Marakovitz; Coalition has issued an interim report; co-convenors are Girls' Club, Office of Mayor, Salva Army, Lynn Community Health Center, Northshore Employment Training, Health Planning of the North Shore and Merrimack Valley; address specific needs of pregnant and parenting teens; form referral, coordinated service networks; plan to compile a

Lynn Teen Pregnancy Coalition (cont'd) report on factors leading to high teen pregnancy in Lynn; existing services and gaps in services; develop an Action Plan to reduce teen pregnancy and assure pregnant and parenting teens access to support services; secure resources to implement Action Plan; implement public information and service coordination programs; needs assessments; community involvement; more than 40 organizations support coalition

14. Peabody

North Shore Catholic Charities Centre
3 Margin St.
Peabody, Ma. 01960

Contact Person: Louise Plesha
Supervisor
Single Parent Program
532-3600

Services: Young Parent Program; individual, family, outreach and counseling; support and parenting groups; foster care and adoption services; family and center-based day care; protective service programs; CHINS counseling program; community services; mental health, day care; collaboratives and do informational speaking, consultation.
Funding Sources: DSS, United Way, Membership Drive, sliding fee, insurance.
Number of Teenagers Serviced Each Year: Pregnant: 100 Parents: 75

15. North Shore Children's Hospital
Young Parent Program-Child and Family Development Center
81 Main Street
Peabody, Ma. 01960

Contact Person: Debra Sosin, LICSW
Director, Young Parent Program
745-2100

57 Highland Avenue, Salem, Ma. 01970
Services: Clinical Case Management-Individual, couple, family and group counseling; parenting skills; concrete services-assistance with AFDC, WIC, Healthy Start, Pre-natal care, pediatric care, etc.; educational/vocational services-assessment, counseling, tutoring, GED assistance; access to ET and other employment training programs; family resources-foster care for pregnant teens or mother and child together; housing advocacy-basic life skills; outreach and community education; offer a Decision-making for Parenting in schools; groups, workshops, films, in-service for guidance and teachers; collaboratives with Project RAP of Beverly and North Shore Community Mental Health Center, Minorities Services Unit of Salem; YPP staff are based at these agencies to be able to provide comprehensive services to larger area.
Funding Sources: DSS, Private donations
Number of Teenagers Serviced Each Year: Pregnant: 45 Parents: 45

16. Office for Children
83 Pine Street
Peabody, Ma. 01960

Contact Person: Lynn Boschetti
Child Advocate Coordinator

25 Exchange Street
Lynn, Ma. 01901

Services: Information, referral, advocacy

Funding Sources: State
Number of Teenagers Serviced Each Year:

HEALTH SERVICES: MASSACHUSETTS — HEALTH SERVICE AREA VI

Reading

17. Catholic Family Services
6 Salem St.
Reading, Ma. 01867

see #10

Contact Person: Cheryl Kristoph
B.J. Capistran
942-0690

Salem

18. Visiting Nurse Association of Greater Salem, Inc.
27 Congress Street
Salem, Ma. 01970

Contact Person: Gail B. Gall, RN-C, A.N.P.
745-9050

Services: U.D.A.G.-Prenatal classes and mothers support groups in Spanish Assessment, referral to clinics and WIC programs; free home visits to mother and child; integration with public and private social services agencies; referral to family planning clinics; home visits for postpartum and newborn assessment, health education based on referral by pediatrician; outreach-screening and health education; support counseling and direct care; collaboratives.
Funding Sources: Medicare/Medicaid, private insurance, Public Health Nurse funded by City of Salem Health Dept., Bilingual Community Health Nurse and aide funded under U.D.A.G., City of Salem.
Number of Teenagers Serviced Each Year: 285 teens serviced each year; no statistics kept of pregnant and parenting teens.

Wakefield

19. Bethany Christian Services of New England
62 Foundry Street
Wakefield, Ma. 01880

Contact Person:
246-1890

Services: Counseling to women, birth fathers and their extended families; housing for some with no alternatives-duration of pregnancy and up to one month post-delivery; foster care; adoptive services for those choosing this option; assist in housing search; follow-up counselling
Funding Sources: Private
Number of Teenagers Serviced Each Year: Pregnant 75 Parents: 70%

SURVEY RECOMMENDATIONS HEALTH SERVICE AREA VI

A total of 10 surveys were returned from this area. Recommendations are broken down as follows:

60% stated that housing was needed. Housing needs range from transitional housing, to permanent housing; residential group homes for pregnant and parenting teens and for older teens and their children; supervised apartments; there was 1 recommendation for housing advocacy.

40% stated that sexuality education was needed. Programs in this area should include advocating abstinence; should be from K through high school; promote self-image; impart information; be culturally sensitive.

30% stated that day care services were needed. One recommendation stated that these services were needed with supportive services.

20% stated that school-based programs were needed. One stated they were needed with family planning included; one stated they were needed with day care included. One recommended that there should not be school-based programs that would advocate referrals for abortion and contraception.

10% stated that each of the following recommendations were needed.

funding for pregnant and parenting teen programs
funding so programs can continue
family planning
acculturation programs for middle and high school students
preventive education, with a self-esteem model
sexually transmitted diseases prevention programs in schools
job skills training
community-based outreach for prenatal care
independent learning programs
social services affiliations with junior high school programs for early intervention
sharing resources
parenting skills
home visits
early intervention
expand health care and education facilities, improve accessibility to education programs
linkages with existing agencies and institutions
expand recruitment and preparation of minority students in health and educational professions

Introduction

A review of the educational research strongly indicates that improved educational opportunities and stronger schools would reduce unwed parenthood. Improved educational opportunities include alternative programs, remedial education, values teaching, sexuality and family life education, child, youth, and family development, communication and skills development, life planning and decision-making programs, school-based clinics, and a full range of multiservice programs. Some youth need intensive special education programs, basic skills learning and development, work-study opportunities, and enhancement of motivation and life options choices. Many need combinations of education and pre-employment skills training, combined with counseling, social services, and day care.

Joy Dryfoos states, "Schools could be, and should be, the loci for assisting youngsters long before they reach the level of alienation and academic failure that causes them to drop out and have babies."[286] There are low cost educational interventions that can be successful in retaining high risk youth in school, and in raising their level of performance, aspiration, employability, and continuation in education.[287] Special education initiatives have proven successful in lowering the rate of repeat pregnancy among teen mothers, and "may prove to be instrumental in reducing the probability of pregnancy among teenagers who have not yet become mothers."[288]

Dryfoos and others, state that other institutions also need to be involved, such as families, churches, social agencies, and community agencies. Teens need role models, and often their families are not able to be counselors and instructors for their children, as they are frequently beset with survival needs and crisis situations.

Factors have been identified as being key to secondary school success:[289]

1. students'perceptions of the connection between present schooling and prospects for future life options and opportunities
2. mastery of basic cognitive skills and social skills
3. perception of the relationship between competency as a teenager and performance as a student, with successful transition to the roles of adulthood
4. reinforcement of success and achievement at appropriate level

In order to reduce feelings of isolation that are experienced by many teens, including pregnant and parenting teens, those who are in school should be mainstreamed as much as possible into the academic setting of school, and should take part in the social spheres. Mainstreaming can be accomplished for many students; others may need support services, and other educational alternatives. Still others may need specific educational components to help them participate fully in, and complete their educational programs. Many schools have established alternative school programs for pregnant and parenting teens, either within secondary schools, or in separate facilities. These programs are "intended to help students maintain academic standing, but learning is individually paced and instruction is responsive to individual differences in students' past performances, abilities, and attitudes. Alternative programs provide special instruction in sexuality education, health and hygiene, life planning, life skills training, parenting education, and job training.[290] Many programs include on-site child care, and many link students to other services and supports within the community, for example, family planning, nutrition supplements, prenatal care, income supports, housing and other services.

Introduction

The Children's Defense Fund states, "for those teens who lack adequate life options and thus lack compelling reasons to delay pregnancy, capacity-building programs alone will not be enough to help them successfully avoid pregnancy."[291] Teens also need assistance in increasing their life options by increasing their basic skills, knowledge, and self-esteem, their information, exposure to a variety of adult roles and role models, and basic opportunities.[292]

CDF also points out that the poverty of a child's family is a strong factor in educational achievement, but not as strong a factor as the poverty of that child's school district. "A poor child in a financially sound school district will do better than one attending school in a low income school district. Educationally disadvantaged children are those who have been denied adequate opportunities to develop and learn in their early childhood or their school years."[293]

Educational programs, whether school-based, alternative, vocational, work-study, or dropout prevention, must include corrections for inequities, such as poverty, and populations with large numbers of disadvantaged children.

The report from the Women's Educational Equity Act Project states that instructional strategies must incorporate group activities and collaboratives that complement female cognitive development, and that sex role bias and stereotyping must be reduced in all educational settings, with barriers to full educational choices by females reduced and eliminated.

The authors of the report cite the characteristics of successful programs:[294]

1. determine which factors are causing students to drop out
2. sensitivity to females vs males learning styles, educational choices, etc.
3. comprehensive, multiservice programs
4. local input at all phases of planning and implementation to remove barriers
5. collaboration and cooperation; coordination

The Children's Defense Fund has outlined some strategies schools can implement to help prevent high-risk students from dropping out:[295]

1. Early identification of at-risk youths, without labeling, through individualized, self-paced programming and positive reinforcement.
2. Build links with parents and community institutions.
3. Opening the schools' doors to resources needed by youth.
4. Incorporating life planning and decision-making into school curricula.

In an interview with Dr. James Comer, published by the Children's Defense Fund, "A Prescription for Better Schools", Dr. Comer states,[296] "schools must broaden their roles in developing children's social as well as academic skills. Students are underdeveloped in certain ways and are not receiving socially the kinds of experiences they need, and interactions with parents and others that will help them deal with the complexities of this age." Among other suggestions made by Dr. Comer:

- school staff are not developmentally-oriented or relationship-oriented
- teachers need child development training, with practical application
- teachers need to learn how to interact with parents, other professionals, and community members
- schools need advisory councils, school planning management teams, steering committees, to address climate issues, academic issues, and staff development issues

Introduction

- families need support, especially those who are out of the economic mainstream, and need help with developing a positive plan for long-range effective goals and opportunities

- programs should address the problems in teen pregnancy, viewed as problems of self-confidence, personality problems, self-destructive behavior

- youth must be influenced across social-economic barriers through linkages to the mainstream community

High School Completion

The high school completion rate increased each year from 1900 to 1965, when it reached 75% for all students. The rate has not increased in the past twenty years, and remains at 75%. In some urban areas, the completion rate is only 50%.[297] One in every two students in urban areas fails to finish high school. Each year, in the United States, approximately 750,000 students drop out of school, 1 in 4 fails to obtain a diploma.[298] By the year 2000, 1 out of every 4 ninth graders will not graduate from high school; 25% of fifth graders do not make it through high school. In 1984, 615,000 teens ages 14-17 and 1.1 million teens 18-19 were out of school and had not graduated.

Patterns of school enrollment vary by race and ethnic group. "Approximately equal proportions of white and black teens ages 14-15 and 16-17 are enrolled in school, while fewer Hispanics are enrolled. Among teens ages 18-19, white teens are more likely to be enrolled than either black or Hispanics."[299] The dropout rate for Hispanics is 50%; for blacks it is 44%, and for Native Americans it is 85%.[300]

Black and Hispanic teens constitute the largest numbers of school enrollments in urban areas in 23 out of 25 of the largest cities in the U.S.[301] If current demographic trends continue in urban areas, future public school student bodies will increasingly consist of poor, minority students.[302] According to the Report of the Democratic Policy Commission, "these disturbing trends in education come at a time when the world of work is demanding greater skills and more education."

In studies conducted by the Women's Educational Equity Act Project, "Female Dropouts: A New Perspective",[303] 38% of dropouts returned and completed their GED by the time their classmates were two years out of high school. "Two factors are important: students who left school at earlier ages were less likely to return; white men and women were equally likely to return; Hispanic and black males were more likely to return and complete high school than young Hispanic and black females. In urban areas, young males were more likely to return and complete high school than young females - 43% to 25%."[304]

In the United States, 23 million adults are considered to be functionally illiterate, more than the national unemployment rate.[305] According to the Children's Defense Fund, many students are chronic truants, are repeating grades without mastering the material, and are advancing and graduating without acquiring basic academic skills. "The gap in academic achievement between black students and white students is largely a reflection of differentials in family income and educational opportunity. While narrowing, this gap remains unacceptably wide."[306]

High School Completion

Each year, the costs of students dropping out of school mount to billions of dollars in lost tax revenue, welfare and unemployment benefits, and crime prevention. The human costs, the loss of dignity, hope and opportunity, are immeasurable.

Risk Factors

Students at the bottom third of the socioeconomic ladder have 3 to 4 times the dropout rate of those from more affluent families. Youths who by age 18 have the weakest reading and math skills are 9 times more likely to drop out of school before graduation and five times more likely to be both out of work and out of school. Many students experience family problems, a sense of alienation, passivity, and fatalism, and feel that life offers few options and opportunities.

At-risk students are those who are still in school, but are in danger of dropping out because they are alienated, perform poorly, or have personal and family problems. They are often behind in grade level, and performance on standardized tests is one or more grades behind. Results from Barro's "High School and Beyond Survey" in 1984 indicate that males and females gave similar reasons for dropping out: 36% of males and 30% of females cited poor grades; 35% of males and 30% of females cited that "school is not for me".[307] The report on Female Dropouts by the Women's Educational Equity Act Project states that the background characteristics of males and females who drop out are similar: low socioeconomic status, minority status, low parental education levels, low academic achievement, and low self-esteem. What influences females more than males is having a family with a large number of siblings and the educational status of the mother.

In 1983, the National Center for Education Statistics contracted with the Educational Testing Service to conduct a study on why students drop out of school. The following table summarizes these reasons:

Major Reasons for Dropping Out of School
(Percent responding yes to each item)

	Total	Males	Females
Did not like school	33%	35%	31%
Poor Grades	33	36	30
Offered job and chose to work	19	27	11
Getting married	18	7	31
Could not get along with teachers	15	21	9
Had to help support family	11	14	8
Pregnancy	11	-	23
Expelled or suspended	10	13	5

Source: Teachers College Record, Vol. 87, No. 3 Spring, 1986.

Risk Factors

Each year in the United States, 10 million children are held back a grade and repeat at least one grade. From 1977 to 1983, these numbers grew by 25%.[308] "Compensatory education, which costs about $600 per student per year, can save more than the $3400 spent when a student has to repeat a grade."[309]

If current demographic trends hold true, and future urban public schools will contain more poor and minority students. "The public schools will consist of more at-risk students and absolute numbers and degree of disadvantaged will increase. Many of these young people will become part of the growing number of people living below poverty. They are also more likely to be in the juvenile justice and prison systems."[310] Some students do not function well during traditional school hours.

Males are twice as likely as females to leave high school because of behavior problems, including not getting along with teachers, and being suspended or expelled. Males also leave for economically-related reasons.

The influence of school factors on the stay-leave syndrome are not well enough known, and require substantially more research.

According to a study from the Wisconsin Center for Educational Research "dropping out of school is not only a function of the characteristics of the dropout, but is also related to institutional characteristics that negatively affect the marginal student. Research suggests that there is a serious problem with the holding power of the school for these youths and that schools should re-think their approach to the so-called marginal in the hopes of offering some chance of achievement and other positive rewards."[311]

While many studies cite the influencing variables and risk factors that determine a youth's dropping out of school, few focus on the factors associated with being a female. The Women's Educational Equity Act Project study, "Female Dropouts: A New Perspective" states that even females themselves understand little of their own motives and consequences of dropping out.[312] Some influencing factors:

54% of women over 16 are now in the labor force
59% of children born in 1983 will live with only one parent before reaching 18
one-half of all females live in a home environment which illustrates the kind of life they can expect to lead
many young women are "expected" to be married and be taken care of

The authors of the study believe that "many problems we thought had been resolved in the 1960's and 1970's on sex stereotyping with teachers in their treatment of boys and girls, and in the selection of courses of study, still exist". Teachers methods and attitudes often favor boys' learning styles and the development of boys' self-confidence, and are correspondingly less attentive to girls' needs in these areas." Other areas in which the authors believe that boys are treated differently in school than girls are:[313]

* early socialization experiences that teach girls to be less assertive
* cognitive differences in the ways girls and boys learn
* teacher interaction patterns that favor boys' response patterns and learning styles
* curriculum selections that often leave girls without the prerequisite for higher paying jobs and careers

Risk Factors

* academic difficulties of girls are often ignored

* as course choices are often influenced by sex role stereotypes, girls do not choose to enroll in certain courses, such as math. and science, therefore they lack the prerequisite skills for a wide range of jobs

* because girls are often channeled into vocational training programs for jobs with lower pays, less prestige, less opportunity for advancement, their chances for achievement and economic self-sufficiency are reduced

"Four out of five female high school seniors are precluded from taking math, science or engineering courses and are also unable to train for a number of jobs, both traditional and non-traditional because they don't take the necessary high school courses."[314]

The authors state that despite laws such as Title IX, and federally funded programs such as the Women's Educational Equity Act, "women of all racial and ethnic groups remain seriously underrepresented in vocational training programs leading to higher paying jobs. Females comprise more than 90% of enrollment in stereotyped occupations such as medical assistants, stenographer/secretary, nursing LP, and cosmotology."[315]

The number of siblings is critical in determining educational attainment for many young women, especially those who may drop out and have to care for younger brothers and sisters. The dropout rate accelerates faster for young women havint 3-5 siblings, 11.2% to 20%, than for younger men with the same number of siblings, 14.7% to 17.6%.[316]

Many adolescents cling to rigid sex stereotypes as a way of coping with the pressures of the process of self-identification, to excel in personal skills other than academic and career planning, and of dealing with societal biases that place a female at-risk of limiting her options.[317] "Gender differences in cognitive orientation are a well-documented fact. Classroom interaction can discourage the development of girls' skills and self-confidence."[318]

Educational Attainment and Employment Potential

In the past two decades or more, educational attainment has become more significant in determining a young person's life chances...education affects one's income and occupational opportunities and employment potential.

Currently 64% of dropouts work for the minimum wage.[319] Only one in five dropouts is employed. Dropouts are twice as likely to be unemployed as those who remain and complete high school. Minorities are three times as likely to be unemployed if they are dropouts. Those students with no more than an 8th grade education are three times as likely to be poor in adulthood as those with a high school education. A dropout earns an average of $2500-3000 a year less than a person who remains in school, by the time he or she is 25. These numbers exclude those who go on to college.

According to the Children's Defense Fund, regarding the earnings of young

Educational Attainment and Employment Potential

men, "young men between the ages of 20 and 24 who had not completed high school have experienced the largest percentage drop in their real annual earnings during the 1973-1984 period - 42%. Only 4 in 10 white male dropouts, 3 in 10 Hispanic dropouts, and 1 in 9 black dropouts earned enough in 1984 to support a family of three."[320]

The authors of the study from the Women's Educational Equity Act Project state that the median income for women is $6,868, and for men it is $15,000, citing that "inequity directly contributes to poverty."

The study further points out that there are occupational advantages for young women who do obtain a diploma:[321]

- 61% of female graduates hold white collar positions vs. 25% of female dropouts
- 51% of female dropouts hold service positions vs. 20% of female graduates
- women earn 64% of what men earn; female dropouts earn 29% of what male graduates earn

School-Leaving and Teen Pregnancy

There are various factors that determine a young woman's pathways to welfare dependency and poverty. A major factor contributing to this course is the lack of education, a factor that is amenable to intervention by accessing teens to school and giving them the supports to remain in school.

Of the 208,390 young women 17 and younger who gave birth in 1980, 89% had not completed high school; of the 353,940 mothers ages 18-19, 45% had not completed high school.[322] Of all teen mothers in the U.S., two-thirds have not finished high school, 10% have not finished the 9th grade, only 1.6% have finished college.[323]

The more motivated a young woman is in regard to furthering her education, and career, the less likely she is to consider becoming a teen parent. The older a young woman is at first birth, the more education she is likely to receive. The reverse is also true: the more years of schooling a young woman has completed, the more likely she is to delay childbearing.[324] Young women who give birth while in junior high or senior high school, complete fewer years of school, are less likely to earn a diploma, and are less likely to go to college than those who delay childbirth. Teen fathers are also negatively affected, but not to the same degree. Teen fathers are 40% less likely to graduate from high school than older fathers.[325]

Teens with low self-esteem, low school achievement, and low aspirations are more likely to become pregnant and become young mothers.[326] Teens with poor basic skills are five times as likely to become mothers before age 16 as are those with average basic skills.[327] Those who give birth at ages 16, 17, and 18 are at greater risk of not finishing high school than those who give birth at younger ages. Hofferth[328] states that teens who have a first birth at younger ages are more likely to stay in their parental home and therefore to stay in school or return to school. Furstenburg and Crawford state that, in contrast, those who give birth at ages 16-18 are more likely to make other adult transitions at the same at the same time, for example, to establish independent living arrangements, get a job, get married, all of which makes it more difficult to continue their education.[329]

School-Leaving and Teen Pregnancy

If income levels and basic skills attainment are considered, minority and white birthrates are essentially the same, as adolescent pregnancy is correlated with income deficiencies and basic skills deficits, and the reduction of teens' life options. [330] Once they have left school, minority teen women are less likely to return.[331]

According to the report of the National Research Council, "while many young women drop out at the time they give birth, it appears that many others drop out during the year before birth of their child. Many young women who drop out become pregnant within several months after leaving school."[332]

Koray Tanfer of the Institute for Survey Research at Temple University conducted a survey on the temporal order of pregnancy and school dropout in 1983. The subjects were never-married 20-29 year old women who had had a pregnancy. The results are as follows:

	White	Black	Total
%Pregnant before dropout	29.7	50.9	39.4
%Pregnant after dropout	70.3	49.1	60.6
Number of months between dropout and pregnancy:			
Pregnant Before	3.3	11.8	7.5
Pregnant After	23.4	14.1	17.5

Source: "Premarital Pregnancy and School Dropouts: A Research Note", Koray Tanfer, Inst. for Survey Research, Temple Univ. 1983.

Preliminary findings from the survey conducted by the Task Force with pregnant and parenting teenagers indicate that:

52.9% had dropped out before becoming pregnant
35.2% dropped out during pregnancy
11.7% dropped out after giving birth

Studies have been conducted on women who had given birth while in their teens to determine whether or not they had "caught up" and completed their education. In general, Hofferth states that they do not catch up, though many do make some progress, especially when they are in their late twenties. However, teen mothers do not catch up completely, with the effects somewhat less pronounced for young black women than for white women. This may be due to the fact that black families and the black community often offer the necessary support mechanisms to help young unmarried women cope with early childbearing. (Hill, 1977, Williams, 1977)[333]

In the Baltimore study by Furstenburg and Brooks-Gunn,[334] at the 17 year follow-up, more than one-half of all educational attainment in the sample took place six or more years after birth. More than one-half of the young women in the study reported at least one year of additional schooling after 5 years of

motherhood, while a significant number went on to postsecondary schooling. Although the results do not suggest that these mothers completely caught up, they do indicate that many teen mothers who interrupt schooling to have a child do resume their education later in life.

In their research paper, "Educational Attainment Among School-Age Mothers: A Review of the Literature and Implications for Policy"[335] Jeanette Valentine and Fern Marx state, "young mothers who performed well prior to the pregnancy and had high motivation for school were most likely to return, to stay, and complete their education. Those with rapid subsequent births were unlikely to successfully complete a high school program. Those who marry tend not to return to school." The authors also state that those teens who have families that contribute support, especially child care, have a better chance of completing school. The paper cites Presser, who found that those teens who had second births within a 45 month period experienced school and work attrition rates of 50%. Those who return to school have fewer subsequent pregnancies than those for whom pregnancy precipitates school dropout. The paper refers to research from Moore and Waite[336] which states that young women from advantaged family backgrounds, fewer siblings, higher paternal education and intact families appear to have an easier time coping with the responsibilities of motherhood and with attending school.

The authors cite the study in 1983 by Project Redirection stating that the availability of support services and case management which facilitates service utilization appears to play an important role in supporting young parents return to school."[337]

The authors give recommendations for the return of teens to school;[338]

* poor motivation and lack of educational success needs individual attention

* development of more extensive life options through expanded and improved vocational education and career counseling

* special programs aimed at the prevention of subsequent births

* support services for those youth from families who are unable or unwilling to help

* attention must be paid, with support services, to personal and familial characteristics and structural factors influencing teens return to school, or remaining in school

The study in the American Journal of Public Health on early subsequent pregnancy among disadvantaged teen mothers indicates, "among motivational measures, only two school-related behaviors were significant predictors of a repeat pregnancy; whether the teen had been enrolled in a school program at the time of the initial interview, and how often she had dropped out of school. Teens who had less of a dropout record and were in school at baseline, were significantly less likely to have a repeat pregnancy than other teens, even when other factors were controlled."[339] Also, teens with a subsequent pregnancy were less likely to be working or to have a positive school status, and more likely to be receiving AFDC than those teens who avoided another pregnancy.[340] "The subsequent pregnancy appears to have exacerbated the problems that are typically associated with early childbearing."[341]

A Rand report for the National Institute of Education[342] states that once a teenager has decided to keep the baby, a decision must be made to stay in school, or leave. Unfortunately, many times this choice is made long before the school is informed, if it is informed at all, thus making intervention services and supportive help almost impossible. According to the report, "these decisions depend heavily on personal motivation and peer and family pressures."The role of the school personnel in identifying high-risk students, and helping marginal students make informed choices about what options are available to them is critical in dropout prevention, or in retrieving students who have already dropped out, or who have high rates of absenteeism.

Children of Teen Mothers

The children of teen mothers tend to be poor and less well-educated, are likely to grow up in disadvantaged neighborhoods, attend low quality schools, and experience high rates of family instability.[343] Some score consistently lower on intelligence tests, and on vocabulary and block design. "Children's intelligence scores decline by approximately one point for every year of schooling that the mother does not complete, according to studies.[344] "The mother's education is a major factor affecting children's achievement scores, with substantial and consistent differences on almost every measure favoring children of more educated mothers."

In a study by Moore in 1986, "the children born to mothers who had fallen behind or dropped out of school before their first pregnancy had considerably poorer cognitive performance than children born to mothers who were in school or on grade when they became pregnant, or who continued in school after their first child was born."[345] Furstenburg's study indicates that by the time the children in the Baltimore study were in high school, many had dropped out, and their school performance was poor. Half had repeated at least one grade, and one-fourth had been retained at grade level for more than a year. Furstenburg also found that the children in the study sample experienced high rates of school behavior problems, suspensions, were runaways, stopped by the police, and as having inflicted serious injury on another person. Findings also indicate that these children are often involved with substance abuse and early sexual experience, though other factors may also influence these behaviors. The children often experience a lack of parental support, family instability, learning disabilities, delinquency and frequently abuse, though further study is needed in this area.

In Massachusetts, over the next five year period, over 37,000 children of teen parents will begin to enter kindergarten and pre-kindergarten. Many of these children will require remedial education, special education, and other supportive services, in school and in other areas of their growth and development. Some of these children will be identified as high-risk children, or as children experiencing problems and difficulties. Many will not be identified until later when other problem behaviors and learning difficulties surface and become compounded.

Massachusetts

1.3 million, or 30% of the adult population have not finished high school. Dropout rates are higher among disadvantaged groups, such as minorities, immigrants, and refugees. Nearly one-half of these adults have failed to finish the 9th grade. In several Massachusetts urban schools, the dropout rates are 39%-43%. Nearly 1.5 million children live in families where at least one parent is functionally illiterate.

A report on teens who drop out of school in Boston, "A Working Document on the Dropout Problem in the Boston Public Schools" states, "there are many factors contributing to teens dropping out - pregnancy, poverty, family problems, and social and behavioral problems." The report indicates that each senior class since 1981 has increased by 2% each year in the percentage of dropouts, from 36.2% in

1981 to 43% in 1985. Nearly 1500 females, or 41%, of the total dropouts, and many of them were pregnant, parenting, or became pregnant. In 1985, 3,026 youth over 16 dropped out of Boston schools; 2,978 graduated. Among these dropouts, 58% were boys, 42% were girls; 27.2% were white and the remaining were minorities. Among those who dropped out in 1984-1985, 30% were in the 9th grade, 31% in the 10th, 26% in the 11th, and 14% were seniors who did not graduate.[346] Rates were higher for blacks and Hispanics, and for those receiving special education instruction. In June, 1986, 3,000 students graduated and about an equal number dropped out.

Many dropouts have already been suspended at least once. The report states that the Boston schools were losing many "marginal students".

The Mass. Advocacy Center issues a report in November, 1986, "The Way Out: Student Exclusion Practices in Boston Middle Schools". The report stated that 1 out of 5 Boston middle school students does not attend school 85% of the time they are enrolled. Poor attendance is strongly associated with poor academic performance, and both are strong predictors of dropping out. "School conditions that make learning difficult for students and contribute to truancy must be the target for reform. Retention in grade does nothing to enhance students' achievement while increasing the likelihood that these students will drop out."[347]

One out of 10 middle grade students is suspended annually in Boston, a practice that puts many students at-risk. The report states that school climate needs remediation, and programs should be developed that meet the developmental needs of adolescents. "Dropout prevention programs should focus on broadening and diversifying opportunities in the education mainstream so that students with a variety of learning styles, paces and needs can experience success."[348] Though all racial groups have experienced an increase in non-promotion, the percentage of Hispanic students not promoted has increased at twice the rate for all Boston middle school students. Black middle school students are disproportionately retained in grade.[349]

Estimates are that about 50-60% of teen mothers drop out of school, and become reliant on public assistance programs. There are no accurate numbers on how many drop out and become pregnant, or drop out when they are pregnant. However, as previously stated, the survey of pregnant and parenting teenagers conducted by the Task Force indicates that a large percent drop out and then become pregnant. Using the current numbers of teen mothers in the state, about 16,500, this means that between 8,000-9,000 have dropped out and become reliant on welfare for themselves and their children.

Included in the Department of Public Health's MAPPS study (see section 11), are statistics on the educational status of pregnant and parenting teens at intake of the study. The statistics for each service delivery site are given in the report of the MAPPS study. The total number of clients in the study was 3,368, in 1985. The total number in school was 1,949, or 57.9%; out of school was 1,351 or 40.1%, and the number graduated was 68 or 2.0%.

Title IX of the 1972 Education Amendments

Title IX prohibits discrimination in education because of pregnancy, childbirth, or marital status. All school systems receiving federal funds must allow students to remain in school throughout their pregnancy, and to return to school following the birth of their child. Expulsion or exclusion of pregnant students from any programs, courses, or extracurricular activities is prohibited. Title IX mandates that the pregnant student, regardless of marital status, has the same rights and responsibilities as any other students.

Schools are permitted to offer separate programs and special courses to pregnant students, but these programs must be voluntary and the instructional component must be "comparable" to the curriculum provided non-pregnant students.[350] Students are to be allowed to re-enter school at any time after delivery without a physician's permission unless such approval is required of all students who have been absent because of a temporary disability.

Many schools have chosen to develop affirmative action programs and policies to reduce school dropout among pregnant teens and to encourage young mothers to return to school.

Despite having these legal rights, many teens experience difficulties in returning to, and remaining in school. School routines, regulations, and facilities are frequently not well-adapted to the special needs of pregnant teens and parenting students. Many schools do not provide the kinds of special supports and services that many mothers need to maintain school attendance.

Chapter I

This program is the largest federal program to help disadvantaged children. It supports remedial education programs, usually in elementary schools, that are designed to give poor children the extra assistance they need to keep from falling behind. There is data that indicates that Chapter I has been effective in helping children. It has saved money by averting the cost of grade retention, which is four times as expensive as Chapter I services.

Chapter I of the Educational Consolidation and Improvement Act replaced Title I of the Elementary and Secondary Education Act. It is directed toward underachieving students in low-income school districts.

Since most programs are targeted at the elementary school level, this program is one means of enhancing school performance, and preventing future school dropout. In this regard, it may help reduce early childbearing among disadvantaged students. Monies at the secondary level often go to schools with relatively large numbers of teen mothers and can provide needed resources to those schools.[351]

Funds are appropriated through formula grants to states based on income and school-age population. Most funds are passed on to the local education agencies. There have been some disputes over regulations.

The 1985 appropriation for Chapter I was 29% lower than that of 1979. Chapter I served only 54 students for every 100 poor school-age children in 1985, down from 75 in 1980.[352] In a 1985 report, the Congressional Budget Office stated that a $1.5 million funding increase would be necessary just to make up lost ground on Chapter I to inflation. HR950, introduced in the House, attempted to address unmet needs by calling for a new program, Even Start, to help parents become more effective in preparing children for entry into school, and to assist with their children's education. The program offers secondary school programs that advance basic skills

Chapter I

improvement and dropout prevention, and would give additional help to local education agencies in counties with especially high concentrations of poor children.

Of the $2 billion earmarked for education reform, only $67.3 million has been targeted to educationally disadvantaged students in only 13 states.

Robert T. Stafford Elementary and Secondary School Improvement Act

On December 2, 1987, the Senate passed a broad educational bill that renews and expands programs affecting most school children, including the federal program for educationally disadvantaged students.

The Act renews programs until 1993, increases spending for some of them and authorizes several new programs. The bill authorizes $400 million for a new compensatory education program for secondary students, and $100 million for over five years for a "star schools" program to support education by satellite transmission. The Act authorizes $50 million for new dropout prevention programs, and $50 million to help school districts buy trailers and comply with a Supreme Court ruling that public school teachers could not instruct private school students on private school grounds.[353] The bill would reserve some money under Chapter I, the $4 billion program for educationally disadvantaged students for school systems in high poverty areas. It reserves 25% of bilingual education funds for methods other than instruction in a native language, compared with the 4% now set aside.[354]

Other sections of the bill authorize spending for programs for gifted and talented children, research, strategy programs that integrate early childhood education for disadvantaged children with adult education for their parents, and programs to increase the involvement of parents in their children's education.[355]

Education Commission of the States

ECS is an information, research, and resource center that has recently launched a two year research and policy effort focused on at-risk youths. The project will examine the role of the school as an educational center and service coordinator for at-risk youths, including how youths are affected by various school practices like student tracking or remediation, and recent state attempts to mount programs targeted to such youths. ECS will provide analysis, technical assistance to states, and will analyze states strategies or environments that foster or inhibit successful programs.

Academy for Educational Development: Support Center for Educational Equity for Young Mothers

According to the Academy, "the goal of the Support Center is to improve educational opportunities for teenage mothers in order to increase their chances of becoming economically secure." The Center assists policymakers, educators, community-based practitioners, and advocates in targeting young mothers for dropout prevention and retrieval programs, and in identifying and implementing successful approaches for helping student mothers. The Support Center conducts research, produces reports, provides training, and offers technical assistance on developing new approaches to educating student mothers.

The School Services Division has established the Center on the "foundation that barriers to young mothers acquiring appropriate education and employment

Academy for Educational Attainment

credentials must be addressed in order to encure equity, to prevent school dropouts, to alleviate poverty and reduce welfare dependency, and to encourage young mothers to delay subsequent children until they are economically prepared to support them."

The Center believes that interventions in schools can have a positive impact on teen parents and their children, thus affecting two generations. "The changing American family forces all institutions, especially schools, to re-examine their roles and responsibilities." The Center also addresses the issue of discrimination against female students through policies and practices that reflect stereotyped ideas.

680 Fifth Ave. N.Y., N.Y. 10019, 212-397-0040

Home Economics Education Association 1201 Sixteenth St. NW, Wash. D.C. 20036

The Vocational Home Economics Education Coalition is an alliance of three professional organizations whose purposes are to maintain dialogue among professional organizations concerned with vocational home economics education. The Coalition identifies existing and potential issues of concern in home economics programs, and has developed a baseline statement regarding home economics education. It reviews positions on current issues and facilitates consensus among organizations, and determines various target groups to communicate issues and positions concerning vocational home economics education. The Coalition has published a pamphlet, "A Quest for Quality: Consumer and Homemaking Education in the 1980's." According to the association, "Consumer and Home Economics Education Programs serve as a vital segment of the whole education system in bringing basic skills, principles, and theories of life for students in their quest for independence." Programs are developed to provide the opportunity for adolescents to gain knowledge and skills essential to become effective parents and to achieve a quality of home life.

The American Home Economics Association Priority Issues Committee "urges the consideration of life's roles as one of the basic foundations for effective citizenship, for individual development, and for maximum contribution to the nation."

The Association cites Spitz, 1984:

1. families are failing to live in harmony
2. productivity is low
3. pride in work is lacking
4. lifestyles such as indulging in smoking, drinking, overeating and failing to exercise causes health problems

Consumers and Homemaking Education "strengthens and improves the quality of life for individuals and families, which is achieved by helping youth and adults gain a better understanding of self and others, especially a sense of personal worth so the individual may develop realistic goals and make responsible decisions."

The Association urges and supports the development of Life Management Skills programs, including making decisions, establishing priorities, assessing and allocating resources, setting personal goals and standards, budgeting, consuming wisely, using goods and services, communicating effectively, resolving conflicts, managing crises, and planning careers.

California

Under the auspices of the California State Department of Education the School-Age Parenting and Infant Development Program (SAPID) offers comprehensive services to pregnant and parenting youth in the public secondary schools. The goals of the SAPID program are to educate school-age parents, including parenting skills, career choices and academic instruction, and to provide care to the infants of school-age parents to enhance their overall health, growth and development. The program encourages the development of locally-determined service delivery models which provide core services of secondary education, parenting education, child care, career counseling, and transportation. Another option, or alternative, to traditional education, is that local programs can operate as an integrated "continuation school", that is, a separate school which offers vocational training, rather than regular academic work.

The legislation establishing the SAPID programs grew out of the lobbying efforts of a coalition of concerned professionals who worked with teen parents, as well as child advocates. At the end of the 1982-1983 school year, 49 agencies were funded under SAPID to administer 64 sites which offer a range of services. These programs were supported by $4.3 million in funds under the SAPID statute. A total of 2,222 parents and children were enrolled in these 64 programs throughout the state: 1,100 infants/toddlers, and 1,122 parents, including 22 fathers. The average cost per enrollee is approximately $2,000 a year.

According to the legislation, at least 15% of program participants must be non-parents, who can participate in the parenting education classes. Guidelines suggest that each local educational agency (LEA) develop priorities for who should receive services, should resources become limited. Each LEA can use its own discretion in admitting participants. Consideration is given to several factors: level of emotional support within the extended family, poverty, potential for child abuse or neglect, and unavailability of alternative child care arrangements.

Services include:

Parenting and non-parent students:

supervised infant care during school hours
representation on the Infant Center Advisory Council
instruction in parenthood education
instruction and experience in child growth and development
instruction in family planning and human sexuality
instruction and experience in career development opportunities
instruction to complete regular high school education resulting in a diploma

For infants and toddlers:

care in licensed child care facility
provide for physical and emotional needs
provide educational stimulation beginning at earliest stages of development
provide proper nutritionplanned under supervision of a nutritionist
provide ongoing social services to children and their families
provide children with opportunity to interact with their parents at the center

When students participate in a mainstream program, local school districts are reimbursed through SAPID funds. The educational program in both the conventional high schools, as well as continuation schools, are supported by the school district's routine ADA funds.

At the local level, programs are encouraged to make maximum use of existing resources from other agencies, but there are no formal mandates for interagency linkages and resource sharing. School districts can develop subcontracts for mandated services where appropriate.

SAPID programs are required to submit quarterly reports to the Department of Education concerning the number of enrollees, attendance, and cost-accounting. Site visits are made as needed, averaging once a year per program. Program quality reviews are conducted every three years. SAPID programs are not formally evaluated for program impact. No analytical studies of program effectiveness have been undertaken.

Colorado

The major focus of this program is to retain pregnant and parenting students in school, and to prevent dropouts. Some localities offer alternative schools, one of these is in Westminster, Colorado, where space is provided in the Alternative High School/Vocational Training Complex for a teen parent program called Options for Young Parents (OYP).

The program is a self-contained high school cirriculum for pregnant teenagers and teenage parents. The principle objectives are to improve self-esteem and prepare the students for the job market. Students attend vocational and academic classes as well as courses related to pregnancy and parenting.

Along with parenting and pregnant teens, fathers are also encouraged to enroll. While students are encouraged to continue school after child delivery at their own high school, most remain in the alternative school. The credits of these students are transferred to their original high schools, and their diplomas are issued by those schools.

The program also involves community resources, such as the county health clinic, mental health and social services.

Tutors are available on an individual basis for vocational education students. As a facilitating means of communication and coordination among agencies, the Colorado Council on Adolescent Pregnancy and Parenthood sponsors directories and other materials on services and other programs available to the teens.

Connecticut

The Center for Interim Education is a comprehensive program for young pregnant women encompassing middle and high school students ranging in age from 12 to 18 years. The program is centrally located in downtown Bridgeport, Connecticut.

The academic program parallels, as closely as possible, the curriculum offered by the Bridgeport schools. All teachers are involved in teaching multiple subjects, and within these subject, multiple levels are taught. In addition, each young woman attending the Center is enrolled in "Preparation for Parenthood", a comprehensive course dealing with basic nutrition, pre-natal and postpartum care, care for the newborn, child development, child psychology, instruction in the Lamase Method of Childbirth, and family planning.

The CIE initially began as a pilot program in March, 1967, with a graduating class of seven. The program has had an enrollment of approximately 100 young women during each of the succeeding years.

In addition to the regular staff, the Center is affiliated with other community agencies, Bridgeport Hospital offers teenage obstetrical clinic services attended by CIE young women. Students from a nearby hospital and the University of Bridgeport's Schools of Nursing and Dental Hygiene visit CIE on a regular basis. The Center works closely with the federally funded WIC program which provides a food subsidy and nutrition counseling. In December of 1968 Westminster Day Care Center was established to care for children from four weeks of age until nursery school, and it affords priority service to children of CIE teen women.

The Center for Interim Education is an alternative educational program seeking to assist these young women in continuing their education and personal development with the goal of becoming competent parents and self-sufficient citizens of the community.

Michigan

Michigan's Interagency Committee for Services to High Risk Children and Their Families has developed a program model called, "Comprehensive and Integrated Model of Services for Pregnant Adolescents, School-Age Parents and Their Families in the State of Michigan". This model is offered for duplication in other states. The model recognizes that the problems of school-age pregnancy and early parenthood are so broad and complex that no single agency can deal with all of them. Interagency cooperation is essential. Since the educational system has the greatest access to adolescents, it is central to any approach to the problem. The model focuses on the services expected of public education and the linkages that should be established with other service providers. It is believed that these linkages should include planning, implementation, and evaluation by local agencies responsible for health, mental health and social services. The model should be implemented by participating agencies involved in interagency planning and coordination.

The model presents a comprehensive package in two settings: the alternative and the conventional school. These options give local or intermediate school districts the flexibility to develop the type of program that would meet their needs.

The model is described in seven sections:

Program goals and implementation
Services to pregnant adolescents and school-age mothers
Services to the children of teens
Services to the teen father
Services to the extended family
Outreach services to schcol-age parents
Teaching responsible sexuality in the schools

Missouri

The Teen Outreach Program, an after-school program consisting of discussion groups and volunteer services, began in 1977 through the collaborative efforts of the Junior League, the Danforth Foundation, and the St. Louis Public Schools.

The goals of the program are to reduce teen pregnancy and encourage the completion of high school. Each Teen Outreach site is located within a school and run by a facilitator, local funder, and Junion League volunteer.

The main premise under which the program operates is the belief that a heightened sense of self-image encourages teenagers to continue their education and to delay parenthood. The program "helps teenagers see themselves as effective, contributing members of their community by placing them as weekly volunteers in community agencies." Teens of both sexes participate in weekly after-school discussions led by a trained facilitator who guides them through a curriculum that focuses on life-management skills. Discussion issues include sexuality, self-esteem building, career planning, substance abuse, teen suicide, and child abuse.

Students are from middle school and high schools. Most are from economically deprived urban areas and are at risk for teen pregnancy and becoming a dropout. Most participants are self-selected. Some receive school credit for their participation.

The Teen Outreach program has developed a comparison group for evaluation purposes. Each participant is required bring in someone from school who is most like him/her. The facilitator compiles information on the comparison group students and tracks them in the future to determine who drops out, who's pregnant, and other information. Evaluations are drawn between students from Teen Outreach and the control group. Teen Outreach program participants were found to be less likely to become pregnant or fail school courses. In 1984, the Mott Foundation funded the initial national replication of the program. Seven new sites opened: Cincinnati, Chicago, Cocoa-Titusville, Holyoke, Minneapolis, Rochester, Yakima. In 1985, there were 24 sites, serving more than 300 students.

Excerpted from Model Programs:
Preventing Adolescent Pregnancy CDF, 86

Teen Outreach Program
8346 Delcrest
St. Louis, Missouri 63124

St. Louis has two tracks of programs for pregnant and parenting teens. The Continued Education Program (CEP) offers pregnant teen-age women the opportunity to attend school classes in a separate school building, under the public school system. About 100 young women enroll each year. The Parent and Infant Interaction Program (PIIP) offers students the opportunity to attend a regular high school, and provides day care within the school. The students attend classes, and see their child during the day. The PIIP program is provided in three high schools in St. Louis.

The objectives of the CEP program are to prevent withdrawal from school by meeting the educational needs of pregnant students; to provide information about pre and post natal care, child care, family relations and career possibilities; to provide a supportive, low stress school environment. Transportation is provided. 358 students were served in 1985. Weekly classes for health education and information are available, as are WIC services and nutrition classes. The program provides basic high school courses and an elementary and special education program. Art, music and physical education classes are also offered.

The objectives of the PIIP program are to assist pregnant and parenting teens to remain in school, earn a diploma or its equivalent; to facilitate the interaction between teen parents and their children and to improve awareness and utilization of health facilities; to support the teen's use of family planning methods, develop life management skills, and to assist the teen parent to develop support systems. 209 students were served in 1985. Prenatal and parenting courses are included, and students are encouraged to have regular checkups. Peer group support and student counseling are also offered. There are plans to expand the number of schools served, and to add a program for teen fathers.

In 1983, the Mott Foundation conducted an evaluation of the PIIP core programs. The study was a continuing longitudinal study entitled, "Long Term Follow-Up Evaluation of the First Three Program Years". The report indicates that the program met its objectives to:

1. Reduce the incidence of repeat births. Over the three year study there were 13 to 14 fewer births, 28% less than expected by staff.

2. Increase the percentage completing high school or GED. Peer group programs were more successful than those dealing with individual students.

3. Reduce the incidence of low birth weight babies. Prenatal groups had 6% low birth weight.

4. Increase preventive health behavior. Children of participants received 'adequate preventive care' but were not more regularly seen by a doctor or clinic than the National Center for Health Statistics survey sample.

The report cautions against the significance of these outcomes in that many students were lost to follow-up. Many youth who are unavailable due to frequent moves, disconnected telephones, and other reasons may exhibit different health and school behaviors than those who can be reached.

After School Education and Recreational Activities

Center 54
Junior High 54 After School Program
107th St. and Columbus Ave.
New York, New York 10625
212-866-5554

The program is a six year old, year-round, after school program located in a junior high school. The school program strives to encourage the community to view the program as a supportive resource.

Four community agencies help provide the wide range of programs:

Bank St. College sponsors the Basic Skills Academy, a GED program for older adolescents 16 to 21.
The Ryan Health Clinic helps with health education and serves as the main referral agency for the center's teens with health care needs.
The Manhattan Valley Youth Outreach Program provides mental health counseling and leadership training.
Basic support from the Rheidland Foundation allows the staff to operate a variety of supportive programs that help keep teens in school and on grade level.

The staff provides remedial academic assistance, homework monitoring, and tutoring in the Learning Center. Social workers go out to find teenagers who are absent from school, make wake-up calls, provide after-school counseling, and provide family advocacy when truancy problems are linked to basic unmet family needs, such as housing. Staff members escort youths to after-school appointments and job interviews.

The center staff consists of three social workers, four part-time teachers, three child care workers, and two activity specialists, and serves about 450 students a year. Components are:

* A strong staff receptive to the needs of adolescents.
* A strong program of physical activity.
* Opportunities for adolescents to define themselves as well as to develop a sense of competence and achievement.
* Activities that allow for creative expression and meaningful participation balanced with a structure and a set of limits.

A Teen Council gives youth the opportunity to help create programs that include a range of programs such as creative arts; remediate gaps in basic skills. Evaluation studies are currently being conducted.

Basic Education, youth employment

STEP: The Summer Training and Education Program
Public-private Ventures
399 Market St.
Philadelphia, Pa. 19106
215-592-9099

Public/Private Ventures is a national nonprofit organization which designs, implements, and evaluates efforts to improve the educational and employability levels of

disadvantaged youth. In 1984 it began to test an experimental program called STEP in two pilot sites, Boston and Pinellas County, Florida. In 1985, permanent demonstration programs were set up in Boston, Seattle, Portland, San Diego and Fresno. The projects are supported by public funds from local governments and the federal Summer Youth Employment Program (SYEP). The program also receives funding from private and corporate foundations, including the Ford Foundation.

The goals of STEP are:

* increase participants' academic achievements and career awareness
* develop ability to make responsible decisions about sexual behavior
* to target low income youths, between 14 and 15, and those youths who are educationally deficient and economically disadvantaged

Components include remediation, work experience, life planning, and social support.

Work experience is provided through STEP and most participants are likely to be employed in entry-level jobs. The life planning curriculum is aimed at developing responsible social and sexual attitudes and behavior, and covers topics such as decisionmaking, workplace behavior, job equality, the consequences of teen pregnancy, and avoidance of pregnancy.

STEP participants show increased academic knowledge, and more knowledge about birth control and the consequences of early parenting.

Excerpted from the Children's Defense Fund, "Model Programs: Preventing Adolescent Pregnancy and Building Youth Self-Sufficiency", July, 1986.

School-based Family Involvement

An Alternative National Curriculum
Brigham Young University
Department of Family Sciences
Provo, Utah 84602

The project serves pre-adolescents, adolescents and parents in Albuquerque, Salt Lake City and Spannish Fork, Utah, and several areas in California. It began in 1982 with funding from the Office of Adolescent Pregnancy Programs.

The major premise of the program is that improved parent-child relations and communication will prevent and reduce early adolescent sexual activitity and its associated problems. Parents are involved in the education of adolescents about family living and decisionmaking, in order to enhance the quality of family relationships and to foster a sense of personal control and responsibility.

The curriculum is taught to 10th, 11th, and 12th graders by teachers who volunteer to teach and are trained by project staff. Some projects have included

younger students. Teachers present the material as part of their standard health, family life, child development, personal development, social studies or home economics curriculum for a minimum of 15 days. Students are assigned interactive parent-child homework that requires them to discuss their values and beliefs with their parents.

The project serves a racially-mixed population, 74% of whom are white, 15% are Hispanic, 3% black, 2% Oriental, 2% Native American, and 3% other races.

The curriculum views sexual expression as an issue of psychology and maturation, but as a fundamental part of family relationships past, present, and future. It attempts to show the intergenerational consequences of decision-making generally, and particularly adolescents' choices regarding education, employment, and relationships.

Instruments used to measure outcomes include a Family Strengths Scale, a Parent-Adolescent Communication Scale, Rosenberg Self Esteem Scale, and a Parent Questionnaire.

Preliminary results indicate that communication between parent and child improves, family strengths increase, and less permissive attitudes. Self-esteem also improved and increased.

Excerpted from Children's Defense Fund: "Model Programs: Preventing Adolescent Pregnancy and Building Youth Self-Sufficiency" July, 1986.

Comprehensive Health Education

Chapter 206 of the budget Acts of 1986 established a State Advisory Council on Health Education to the Massachusetts Board of Education, and a Comprehensive Health Education and Human Services Grant Program. According to the Massachusetts Department of Education, the FY87 focus of this program was to assist school districts in planning a comprehensive program and services for grades PK-12.

Through the legislative and budgetary initiatives of State Representative Barbara A. Hildt, and implementation by the Department of Education, guidelines for those school districts who do receive planning grants include:

* A detailed needs assessment to determine what is in place and what is missing from the district's comprehensive health education and human services program in grades PK-12.

* Development of a system-wide plan for inservice education.

* Producing a plan for what steps need to be taken to fully implement a comprehensive health education and human services program.

* Describing proposed linkages with specific state and community agencies including the Departments of Social Services, Public Health or their vendors, Mental Health, and the Office for Children.

* The identification of model school district programs within the state.

Proposals for planning and implementing such programs should contain the following considerations:

* Planning comprehensive school health education and human services programs, PK-12.

* Expanding or supplementing already existing comprehensive health education and human services programs.

The programs are to include, but not be limited to, certain components:

a. Comprehensive health education in grades PK-12.
b. School health services.
c. School counseling and psychological services.
d. Individual educational and psychological assessment.
e. Direct counseling services to students, staff, and parents.
f. Peer education and support programs.
g. Inservice education and support programs.
h. Targeted programs for emerging health issues such as substance abuse, depression, suicide, family and peer violence, injury prevention, child abuse and neglect, teen pregnancy, and AIDS.
i. Programs to promote the family through parenting skills for parents and adolescents, and coursework on child care and development.
j. Extracurricular programs such as health-related forums, fairs, health promotion activities for staff and students, parent seminars, theatre/ health presentations, incentive programs.

Comprehensive Health Education

k. School-based policies and procedures to identify and follow-up students at-risk of suffering health-related problems.
l. Coordination of comprehensive health education and human services programs and services within the school.
m. Coordination of school-based services with community agencies.

According to the Department of Education, a comprehensive health education and human services program is defined as consisting of two broad components:

1. Comprehensive School Health Education is one of three components along with school health services and school environment which make up a comprehensive school health program. Although all three components of the school health program should be included within program planning activities, the focus of this grant program is specifically comprehensive health education. School health services personnel should be involved in the program planning and implementation of the school health curriculum as well as the development and implementation of policies and procedures by which students with potential for health problems are identified.

2. Human Services refers to the school district's counseling and psychological services and the coordination between school programs, parents, and existing community services, especially for those students most in need.

According to the Department, "regional school districts must work with all of their feeder elementary districts to develop a PK-12 planning application. Elementary districts must apply with their respective secondary schools."
The Department acknowledges that there must be coordination among all departments providing services in order for effective planning and implementation to take place. Evaluation procedures are essential in determining if program implementation objectives have been realized, and if the programs affected student attitudes and behavior. School districts should also conduct a search for local resources to supplement the current program, and to target these resources for potential funding.

The Department of Education identifies key people who should be involved in planning:

* administrators - principals, superintendent, curriculum and guidance coordinators
* community leaders - clergy, physicians, school committee, PTA, mayor
* coordinating agencies - hospitals, mental health centers, social service offices, local Office for Children, voluntary aid organizations
* implementing staff - nurse, health teacher, counselor, school psychologist, classroom teacher, home economist, physical education teacher, science teacher
* parents and students

For FY87, a total of $300,000 was available for planning grants of up to $15,000 to local and regional school districts for the planning of comprehensive health education and human services programs in grades PK-12. A total of $60,000 was available through the Commonwealth Inservice Institute to support training for the improvement of instruction and services for comprehensive health education and human services in grades PK-12. Eligible participants are school personnel, parents, students, and community groups.

Comprehensive Health Education

The following cities and towns received planning grants under Chapter 206:

Amesbury Public Schools	$6,400	Mansfield Public Schools	$13,250
Amherst/Pelham Regional School District	5,537	Medway Public Schools	8,530
Cambridge Public Schools	$13,250	Mt. Greylock Public Schools	$ 5,372
Chelsea Public Schools	13,250	New Bedford Public Schools	13,250
Easthampton Public Schools	10,885	North Adams Public Schools	13,250
Fall River Public Schools	13,250	Peabody Public Schools	13,607
Haverhill Public Schools	11,010	Quabbin Public Schools	7,210
Holyoke Public Schools	13,250	Sandwich Public Schools	13,250
Leominster Public Schools	13,250	Sharon Public Schools	13,250
Lincoln-Sudbury Schools	13,250	Shrewsbury Public Schools	11,805
Littleton Public Schools	9,537	Somerville Public Schools	13,250
Lynn Public Schools	13,607	Westport Public Schools	13,250
Malden Public Schools	13,250	Worcester Public Schools	11,000
Total:	$300,000		

For FY88, $1.5 million has been allocated for planning and implementing programs in school systems for the Comprehensive Health Education and Human Services Grant Program.

Program Descriptions

The following program descriptions were selected randomly in order to give examples of the types of programs being planned and implemented through the grants.

Amesbury

Funds will be used to implement a 4-6 and expand a 7 and 8 grade health education curriculum, develop a human services resource manual for parents, design a health resource center at the middle and high school libraries and hire a human service administrator to develop a human services delivery plan for the system.

Chelsea

A health educator will be hired to complete a K-6 health curriculum, establish a health education resource center, and provide training and support for curriculum implementation. A crisis intervention counselor will be hired to develop resources and train staff on counseling needs for students referred due to substance abuse, teen pregnancy, depression, suicide, and child abuse.

Easthampton

Easthampton will implement a coordinated health services and health education program for PK-12. Two full-time health educators and a part-time group facilitator will be hired.

Holyoke

A health education coordinator will be hired to revise the health education curriculum beginning with grades PK-6, and phase the curriculum into schools as pilot programs. The coordinator will work with Holyoke Hospital and the Holyoke Board of Health to plan and implement inservice education, for school staff. Part time teachers will be paid as curriculum developers. A liaison specialist will be hired to work with citywide parent councils, conduct community meetings and write and disseminate a program newsletter.

Littleton

A part time project coordinator will coordinate the development of a K-12 health curriculum, the establishment and training fo referral teams, and the creation of a parent awareness program.

Lowell

A part time transitional project facilitator will be hired to revise K-8 health curriculum, to provide inservice training to implement the curriculum, to coordinate policy/procedures around various health issues and coordinate school services with outside agencies. A part time school psychologist will provide assessment and individual and group counseling services for at-risk students.

Peabody

A health resource aide will be hired to coordinate a health education resource library. Consultants will be hired to offer parent education programs and existing staff will be paid stipends to create a PK-12 health education curriculum and to run peer programs.

Sandwich

A health education coordinator will be hired to plan inservice and parent education programs and to review the secondary health education program.

Mount Greylock

A school health coordinator will be hired at the elementary level, and release time will be provided for teachers to attend health team meetings and inservice training in health and human services. Consultants will be hired to assist in public relations, to coordinate and present at a school/community health conference, and to provide psychological services. Health Skills for Life (a comprehensive health education curriculum) will be purchased and teachers will be trained for its implementation. A peer resource team will be trained and utilized within the school system.

Cambridge

Pulling Together for Health supports two staff developers for health education to implement a comprehensive elementary health curriculum for the first time in Cambridge. The grant supports a process for developing an integrated secondary health curriculum as well. A strong inservice component targets teachers, counselors and administrators for training in AIDS education and substance abuse prevention education.

Chapter 188 Dropout Prevention Programs

Massachusetts General Law Chapter 15, Section 52, as inserted by Chapter 188 of the Acts of 1985 established an essential skills discretionary grant program. Twenty-five percent of the funds appropriated under this section are allocated for dropout prevention programs. Subject to appropriation, the Board of Education may award grants to local school committees to develop and implement supplementary dropout prevention programs for grades seven through twelve. These grants are awarded on a competative basis to school districts. Preference is given to school districts with high concentrations of students from low income families and documented high dropout rates for the most recent three years. According to the Department of Education guidelines, "the intent of this legislation is to provide local school districts with additional resources beyond already existing federal, state, and locally supported education and dropout prevention programs."

The Department of Education has issued guidelines, eligibility, planning and participation requirements for those wishing to offer proposals for the grant monies.

Each participating school district must create a broadly representative dropout prevention advisory council, comprised of administrators, teachers, parents, students and representatives of business, labor, higher education, and other community agencies, that oversees program development and implementation.

According to the Department, "funds may be used to plan dropout prevention activities, to expand or supplement already existing dropout prevention programs, or to implement a new dropout prevention program. Funds may be used to supplant programs and services provided under Chapter 71A (Transitional Bilingual Education), 71B (Special Education), and 74 (Occupational Education)."

The Mass. Board of Education awarded funds to 39 school districts for programs in FY87 - 29 planning grants and 19 expansion and new program grants. Grants totaled $2.9 million.

The Department of Education has stated that there are basic premises upon which effective dropout prevention programs should be founded:

1. The school community is committed to provide educational services to all eligible students, including those most in need of services and at-risk of leaving school prior to obtaining a high school diploma.

2. Many factors contribute to students leaving school early, poor reading skills, academic failure, boredom, problems due to socioeconomic status and finances, pregnant and parenting teens, lack of person attention, academic support and counseling services, ineffective and rigid disciplinary and attendance policies, a family or peer history of leaving school, racial or gender discrimination, social isolation, drug and alcohol-related problems, health problems, family problems and mental, psychological or behavioral problems.

3. Significant numbers of students leave school or think about leaving prior to the tenth grade. Programs should be targeted at middle school as well as secondary school.

4. To avoid becoming a "dumping ground" for "problem" students, effective dropout prevention programs contain a varied student population, are voluntary, and are geared to make schools more effective for all students.

5. Effective dropout prevention programs combine identification, intervention, and evaluation components that work together.

6. Many students drop out of school because they feel isolated and lack a sense of belonging. Programs should include academic achievement, high expectations for staff and students, caring and support, career awareness, raising of self-esteem.

7. Programs often contain a basic skills and remedial component, emphasizing literacy. Efforts are made to develop effective instructional approaches and curriculum designs that are multicultural, experiential and enriching.

8. Programs should include a wide range of coordinated support services and employment opportunities.

9. Chronic truancy, tardiness, and cutting classes may indicate that a student is considering dropping out.

10. Some students may have a history of repeated school disciplinary infractions that result in multiple suspensions and eventual school leaving. Measures should be taken, including allowing for appeals, flexibility in applying punishments, early identification procedures.

11. Inservice education for teachers and staff on indicators and identification of at-risk students, referral procedures, and programs and practices that address needs.

12. Student participation should be maximized in decision making, communication, and involvement with development and implementation of programs and policies.

13. Parental involvement should be included in programming, involved the coordination with adult support and education programs.

Among the program models, and components of programs, is the Adolescent Parenting Program, defined as a program structured for pregnant and parenting teens in which prenatal and/or child care is provided to enable student parents to attend school, and in which the parents or expectant parents, males and females in addition to core academic classes, attend classes and receive counseling and support encompassing parenting and parenting skills. The rationale is that pregnancy and parenting is one of the most frequently identified reasons female drop out of school. Schools have traditionally lacked the support services teen parents need to remain in school.

The programs described on the following pages are those that focus specifically on pregnant and parenting teens.

Planning Grants

Weymouth Public Schools: "Pregnant and Parenting Teen Program"

The planning group is developing a comprehensive pregnant and parenting teen program to be located in one of Weymouth's three high schools. Activities include

coordinating school resources and agency services, identifying program participants, developing classes and programs, developing life education classes for all students, and conducting in-service training with staff in the three high schools. Ms. Betsy Erickson, Home Economics, N.Weymouth H.S., 1051 Commercial St., E. Weymouth 02189, 337-4500; located in East Junior H.S. Fund: $10,000.

Ralph Mahar Regional School District: "Dropout Prevention", Orange

A pregnant and parenting teen program to be implemented at the school in February, 1987, has been developed. Data on pregnant and parenting teens has been gathered along with interviews of these youth in order to determine program needs. Programs in other schools have been visited in order to integrate exemplary components into a comprehensive program. Mr. Michael Roche, R. Mahar Regional School, South Main St., Orange 01364, 544-2920; location-R. Mahar Regional School, fund - $10,000.

Dropout Prevention Expansion and New Program Grants

Brockton Public Schools: Project GRADS for Teen Mothers"

Project GRADs is a dropout prevention program for pregnant and parenting teenage girls. The program combines academic instruction at Brockton High School, day care for babies of the participating teen mothers, and instruction in parenting skills, pre- and post-natal health, and pre-employment skills. The goal of the program is to enable these girls to obtain high school diplomas.
Dr. Susan Dukess, Coordinator, Brockton Public Schools, 43 Crescent St. Brockton, 02401, 580-7572; location - Brockton High School, Howard School; fund - $33,860.

Easthampton Public School: "Comprehensive Dropout Prevention Program"

This program targets five program areas: 1. the provision of counseling, support and child care education and training to ten pregnant and/or parenting teens; 2. the provision of an attendance case worker to monitor chronically truant students; 3. the implementation of a self-awareness and teen issues course with middle school students; 4. the creation of an alternative ninth grade program for twenty-four at-risk students emphasizing career awareness, support services, academic remediation and school governance; and 5. the development of a parent support group for parents of at-risk students. Alexander Velis, Guidance Director, Easthampton H.S., White Brook Middle School; fund - $69,634.

North Shore Vocational High

The program will assist at-risk youth by supporting improvement of school discipline policies, by developing crisis intervention, peer support, help for pregnant and parenting teen programs, and by providing incentives for perfect attendance, orientation for new students, and inservice for faculty and staff. Fund - $33,525.

Weymouth Public Schools

T.A.P.E. will offer three periods of parenting courses and four to five periods of academic classes per day to approximately fifteen pregnant or parenting teens. Fund - $35,000.

Governor's Alliance Against Drugs

While these funds and programs are targeted to prevention of substance abuse, pregnant and parenting teens, many of whom use and abuse drugs and alcohol, would be beneficiaries of these programs.

In 1987, Massachusetts received $3.4 million to help provide drugs and alcohol education programs for children, and teacher training. Communities will receive approximately $2.00 for every school-age child, which includes those young people who attend private or parochial schools as well as those who are not in school. Communities are asked to develop a three year plan to expand elementary and junior high school drug and alcohol programs, and create or expand peer programs and parent programs. A goal is to provide long-lasting education programs and teacher training to reduce drug and alcohol abuse by 1990.
Drug-Free Schools Act of 1986:

Governor's Alliance Against Drugs, Drug Free Schools Act of 1986:

1987

$2,143,227	Granted directly to all public, private and parochial schools. Applications are filled out by the superintendent and submitted to the Alliance.
$510,292	High risk youth, competative bid process, application through Governor's Alliance.

Justice Assistance Act

$500,000	Competative bid for school or community based drug and alcohol education program, application through the Alliance

1988 and 1989: Approximately the same funding formula as above.

Commonwealth Futures

This program was initiated in July, 1986, to attempt to develop a statewide strategy to attack and resolve the dropout problem. Over a several year period, the program, at the local level, aims to assist broad-based community teams in approximately twenty communities to plan and implement long-term strategies to reduce dropout rates and help disadvantaged youth become economically self-sufficient. to achieve this goal, teams will need to coordinate the work of various organizations and learn to maximize the use of existing state and local resources to address the problem of dropout prevention and re-entry into school. Governor Dukakis has requested $1 million to supplement initiatives in FY88. Communities that have developed plans for Commonwealth Futures are; Boston, Brockton, Chelsea, Fall River, Lawrence, Pittsfield.

There are three basic incentives to encourage local community participation:

1. Local communities will receive on-site technical assistance services; attend Planning and Development Institutes, participate in intercity peer assistance visits to share strategies and models; receive scholarships to attend conferences or workshops.

2. Communities deemed "ready" for paticipation will have access to additional funds.

3. The possibility of a "simpler bureaucratic life" at the local level is central to the State's interagency commitment to develop a single, coordinated application for State assistance.

A total of 21 communities and two regional school districts were identified as containing high concentrations of youth at-risk. Criteria for eligibility included such measures as public secondary school attrition rates, AFDC caseloads, incidence of pregnant and parenting teens, poverty rates, a community's ability to support public education using tax base information, the percentage of youth ages 18 and 19 in a community without a high school diploma, and the percentage of those youth without a diploma who remain unemployed and out of the labor force.

Boston Compact

This program was developed in 1982, when hundreds of Boston firms and businesses joined with city public schools and trade unions to form the Compact. The schools exchange promises to boost student performances for commitments from businesses to provide more jobs for public school youths. Three hundred and thirty-six firms signed a priority-hiring pledge, resulting in a jump in summer job hires from 500 in 1982 to 2000 in 1985.

Since this time, similar compacts have been reached with colleges and trade unions.

There are four measurable goals of the Compact: to increase student attendance, to reduce the dropout rate, to improve student achievement, and to expand the number of graduates who enroll in higher education or who secure full time employment.

School-Based Programs

The following programs are listed in the Listings section of the report, by Health Service Areas (HSA). While many programs provide services and education to school systems, and in school systems, or on-site, the programs listed below are specifically school-based, or provide an educational component in their program, a vocational education component, or GED tutoring and courses, or have an alternative school program in their servicing components. Many programs have liaisons and linkages with school systems as part of a network, and provide outreach and education in the community as well as in schools. These services are stated in the description of services under each program.

Health Service Area 1

#3. Human Resources Center for Rural Communities, Athol; consulting services to Athol-Royalston School District, Teen Pregnancy Program

#14. Holyoke Teen Clinic, Holyoke High School, Holyoke; see discussion in School-Based Centers Section.

#23. CANBE, Pittsfield

#24. Teen Parent Program, Stearns Schoo l, Pittsfield

#28 P.A.G.E. Young Parents YWCA, Springfield

Health Service Area 2

8. Children's Friend Society, Worcester, School-Age Mothers, SAM

#18. Teen CARE Program, Burncoat Sr. High School, Worcester

Health Service Area 3

#10. Greater Lawrence Mental Health Center, Lawrence, cooperative agreement with Lawrence and Methuen Public Schools to provide mental health services.

#11. Greater Lawrence Regional Vocational Technical School, Lawrence

#12. Healthworks, Lawrence, other locations, GED.

#14. Lawrence Public Schools, New Beginning Program, Lawrence.

#20. Teen Health Service, St. John's Hospital, Lowell, local high schools.

#21. Greater Lowell YWCA, Family Support Center, Lowell, GED, schools.

School-Based Programs

Health Service Area 4

#10. Bridge Over Troubled Water, Boston, GED.

#18. Crittenton Hastings House, Boston

#21. CSAPP, Comprehensive School-Age Parenting Program, Inc., English High School, Boston.

#36. Cambridge Community Services, Adolescent Parent Employability Programs, Cambridge.

#37. Adolescent Parent Program, APP, Cambridge Rindge and Latin School, Cambridge.

#47. Chelsea High School, Chelsea.

#41. Employment Resources, Inc., The Beginnings Program, Cambridge.

#45. Chelsea Community Counseling Center.

#49. Employment Connections, Inc., Chelsea.

#55. Aswalos House, YWCA, Comprehensive Adolescent Parent Program, Dorchester.

#60. Parent Child Center, Dorchester.

#63. Whittier St. Neighborhood Health Center, Dorchester.

#67. Comprehensive School Age Parent Program, Jamaica Plain High School.

#68. Ecumenical Social Action Committee, Inc., Jamaica Plain.

#72. Health Information Referral Service, Marlboro.

#76. Quincy Teen Mothers Program, Quincy.

#79. Dimock Community Health Center, Roxbury.

Health Service Area 5

2. Attleboro Area Youth and Family Services, Young Parents, Attleboro.

#18. New Bedford Child and Family Services, New Bedford.

Health Service Area 6

#10. Second Chance School, Alternative School, Lynn.

#14. North Shore Children's Hospital, Young Parents Program, Peabody.

Section 13, p. 255

The Carl Perkins Vocational Act of 1984

The Carl D. Perkins Vocational Act of 1984 (P.L.98-524) was signed into law on october 19, 1984. The Act provides continued federal assistance for vocational education for five years, through fiscal year 1990. The overall purpose of the Act is to provide vocation education to youth and adults in the country. The law is targeted towards certain special populations, and requires a substantial portion of each state's federal allotment to be spent on program improvement and expansion, on increasing employer participation, and on focusing the planning process on labor market conditions. The law shows increased awareness of the role of community-based organizations in serving special populations. According to Dr. Denise F. Polit, in her report, "Building Self-Sufficiency: A Guide to Vocational and Employment Services for Teenage Parents", "although the federal funds represent less than 10% of all money spent on vocational education in this country, the new bill is important because it helps provide direction to the entire system, and leverages state and local dollars to achieve national objectives."[356]

Among the purposes of the Act are the following;

* assist states to expand, improve, modernize and develop quality vocational education programs...to meet the needs of the nation's future work force in marketable skills

* assuring equal access to quality vocational education programs, especially individuals who are disadvantaged, who are entering nontraditional occupations, and who are single parents

* assist the most economically depressed areas of a state

* improve the effectiveness of consumer and homemaking education and reduce the limiting effects of sex-role stereotyping in occupations, job skills, levels of competency, and careers

In order to be eligible for funding, states must establish a State Council on vocational education. States must submit a State Plan to ensure compliance and provide descriptions of the planned use of the funds. The state must give the methods and procedures the state will use for coordinating programs funded through the Job Training Partnership Act (JTPA), which is described in the section on Job Training Programs. Prior to submitting the plan, the state must hold at least two hearings so the public can make recommendations.

There are only two classes of eligible recipients, that is, entities that can receive subgrants from the state Department of Education: 1. a local educational agency (LEA), or, 2. a postsecondary institution. There are some provisions for funding to community-based organizations, who must work in concert with one of the above two entities.

There are many provisions of the Act that permit funding for services to teen parents. Dr. Polit describes some of these opportunities in her report;[357]

Carl Perkins Act

1. The Act has two separate programs, the basic state grant and special programs, covered by Title II and Title III. Title II has two main programs: Part A, the Vocational Education Opportunities Program. 57% of the basic grant program funds are devoted to this program, which targets specific populations that have traditionally experienced barriers to employment. Three of the six target groups have implications for teen parents:

   - disadvantaged individuals (22% of the basic state grant)

   - individuals who are single parents or homemakers (8.5% of the basic state grant)

   - individuals who participate in programs designed to eliminate sex bias and stereotyping in vocational education (3.5% of the basic state grant

In the case of services to the disadvantaged population, state/local matching funds are required - a 1 for 1 match - but matching funds are not required for the other two. The following gives a brief description of services that can be provided under these areas:

a. disadvantaged: supplemental or additional staff, equipment, materials, services not provided to other individuals in vocational education; targets members of disadvantaged families, migrants, those with limited English proficiency, dropouts and potential dropouts

b. single parents: funds may be used for outreach activities; orientation-career explorations, assessment, self-esteem building; tuition for enrollment in a long-term prepatory vocational program; basic literary instruction; job readiness instruction; educational materials; child care, and other activities

c. sex bias and stereotyping: provides for programs, services, or activities designed to help young women support themselves and their children; can include child care and transportation, educational materials, self-concept building, basic skills instruction, tuition, outreach, job readiness and job search activities, and others

2. Part B of Title II is for vocational education improvements, innovation, and expansion. Funds must be matched with state and local funds on a 1 to 1 match. There are possible uses of these funds for teen parents:

   - new programs in economically depressed areas

   - prevocational education

Carl Perkins Act

- special courses designed to teach math and science
- improvement and expansion of programs for out of school youth and adults
- promotion and recruitment
- counseling and guidance projects
- curriculum development; placement services; day care services
- student stipends

3. Title III is designated for five categories of Special Programs, but in 1985-1986, only one part received funding - Part B. This is for Special Programs in Consumer and Homemaker Education. This program allows for instructional projects, services and activities in these areas:

- food and nutrition
- consumer education
- family living and parenthood education
- child development
- home management
- family and individual health

Matching funds for programs are not required under Title IIIB, but the federal appropriation was relatively small. Appropriations were made for FY86-87. Title IIIA is earmarked for state assistance for vocational education support programs by community-based organizations. This part is intended to serve youth who may be difficult to serve through traditional vocational education programs operated by school systems.

Approximately 90% of the monies expended on vocational education come from state and local sources. The federal government expends nearly $1 billion on vocational education, which goes directly to the states. The states spend the monies according to their state plan.[358]

Federal requirements stiuplate that at least 20% of the funds be spent on the academically or economically disadvantaged: 10% to be spent on the handicapped; and at least 15% on post-secondary institutions. A minimum of $50,000 must be spent on full time work oriented toward eliminating sexual discrimination and stereotyping. An unspecified amount must be spent on either single heads of household, displaced homemakers, and workers in traditional jobs who wish non-traditional work. Day care services for the children of students in vocational education at the secondary or post-secondary level may be included among the support services a state chooses to provide.

Carl Perkins Act, PL 98-524

In January, 1987, the Department of Education issued a report, "Program Performance Report: Federally-Funded Vocational Education". The report contains program descriptions and accomplishments in the areas of the handicapped, the disadvantaged, limited English proficient, adult training and retraining, single parents and displaced homemakers, sex equity, criminal offenders in correctional institutions, and outlines coordinated efforts in the areas of school-to-work transition programs, occupational education/employment and training initiative, with the State Council on Vocational Education, and joint policy on occupational education.

A total of 67,484 individuals were served in 1,152 programs that focused on the academic, occupational and responsibility skills and knowledge required for success in the workplace and for advanced learning. According to the report, "included in the populations specifically targeted for services by the Massachusetts Board of education were pregnant and parenting teenagers, court-committed youth offenders, and welfare clients."[359] The report also documents the continued growth of partnership programs in vocational-technical education.

The programs and objectives funded through The Carl Perkins Act are:

1. Service to target populations to enhance their success in regular vocational education programs.

2. Improvement of both instructional and support programs with particular emphasis upon the improvement of vocational teachers' capacity to design and manage competency based curricula.

3. Coordination of plans, programs and activities with related agencies on the local and on the state level.

Findings concerning the impact of these programs are:[360]

* A total of 1,338 pregnant and parenting teenagers were assisted with programs that included; academic support, to enable the student to complete a vocational education program, training in parenting and child care, and individual counseling. These programs included collaboration with local offices of the Department of Public Welfare and the Department of Social Services.

* A total of 11,779 students were served in programs funded to eliminate sex bias and sex stereotyping. These programs focused on nontraditional career choice, especially for females, or support groups for students in nontraditional study in vocational programs.

* Eight vocational schools developed specialized programs that served 161 committed youth from fourteen Department of Youth Services facilities.

* The Occupational Education/Employment and Training Initiative, begun in 1987, is a collaborative effort between the Division of Occupational Education and the Department of Public Welfare, to provide occupational education and training to individuals receiving AFDC or GR. 31 projects were funded in FY87: 18 in adult training, 3 for support services from community based organizations, 9 summer programs for pregnant and parenting teens, and one project in a correctional institution.

* A total of 29 programs to serve single parents and displaced homemakers were funded to community colleges. These programs provided skills training to 1,331 individuals.

Other findings concerning other programs funded through the Carl Perkins Act are discussed in the report.

The Carl Perkins Act funded monies to school districts and community-based organizations for the excess costs associated with approximately 267 projects for disadvantaged students. These projects provided skills training, academic support, as well as a variety of guidance and counseling services. One important objective of the projects was to reduce the high dropout rate for academically disadvantaged students.

School-to-Work Transition Programs are a collaborative effort among state and local agencies to enhance the employability of educationally and academically disadvantaged youth. The programs are administered by the Education, Training, and Employment Bureau of the Department of Education. A combination of state and local funds are used to support these programs. In FY87, the programs were operated in over 60 high schools and communities across the Commonwealth. The single largest provider, Jobs for Bay State Graduates, Inc., operated programs in 26 high schools in 20 cities and towns, serving a total of 1,320 students. As of June, 1987, this program showed a 68% success rate- 66% of the program participants were already successfully employed, and another 1.2% were enrolled in further training or had enlisted in the military. The most significant and immediate effect that School-to-Work Programs have on their participants is that when students leave the program they are quickly employed, and their long-term job retention rate is very positive.

"Career guidance and counseling includes organized programs, services, and activities for students about to enter, currently enrolled in, or leaving programs of vocational education which provides assistance for making informed occupational decisions, career decisions, or decisions regarding postsecondary education."[361]

Title III, part B of the Perkins Act authorizes funds, beyond those provided by the Basic State Grant, for consumer and homemaking programs. All consumer and homemaking programs were targeted to pregnant and parenting teenagers or to refugees. Priority was given to programs in consumer education, food and nutrition, family life education, parenting education, child development and guidance, housing and home management, and programs to prevent child abuse, spouse abuse, and substance abuse.[362]

In FY87, over $647,000 was awarded to 38 projects offered by school

districts located in both economically depressed and non-depressed communities.

Programs targeted to pregnant and parenting teens included several different elements:

- academic support to enable the student to complete vocational training
- training in parenting and child care
- individual counseling

Programs were developed and operated in collaboration with other state and local agencies. The following are descriptions of some of these programs, excerpted from the Department of Education's Program Performance Report.

Billerica Public Schools, "Project Teen Parent"

Goals: provide pregnant and parenting teens with pre-and postnatal care; instruction in child care; coordinated support services to remain in or return to school after birth

Services:

Students in grades 10-12 participated in a variety of activities and services. Each student met with the health professional in individual and group sessions; the health professional served as a liaison with medical, counseling, and social services agencies.

Through a cooperative agreement with the U. of Lowell, a nursing program student accompanies students to physician visits, offers support during labor and delivery, and made post-delivery visits.

All students met with a vocational resource aide who assisted them in developing long and short-term job and career opportunities.

The staff developed a parenting resource directory.

Boston Public Schools, Parenting for Adolescent Fathers

The project supplemented the Comprehensive School-Aged Parenting Program currently in operation by introducing a model curriculum, designed to prepare teen fathers and fathers-to-be for parenthood. Federal funds were used for the salaries of one instructor and one part-time trainer on teen parenting issues; for travel expenses associated with field trips to agencies and health care centers, instructional supplies.

Fourteen parenting teens and six expectant teens enrolled in English High School were provided two hours a day of support and counseling services. In addition, 41 students identified as high risk received counseling services.

Services:

Activities focus on developing a support network for parenting students; provide students with information on alternatives to parenthood; developing more stable relationships; making job training referrals; enhancing self-respect and life planning; summer program.

Carl Perkins Act

Franklin Public Schools, CARE

The project provided instruction and individual counseling to four pregnant/parenting teens in grades 9-12. Federal funds were used for the salaries of a part-time instructor and counselor, transportation, and instructional supplies. A printed brochure was developed and distributed that described the program.

Four students, including the male partner of one pregnant female student, participated in instruction.

Services: counseling in pre/postnatal care, childbirth, parenting, nutrition skills; skills in managing individual and family resources, and how to deal with a family crisis; use of computers in instruction.

Detailed records of progress were kept, and students were given pre- and post-tests. All four students improved significantly. One female participant's knowledge of prenatal care, childbirth, and care of the newborn improved 30%; knowledge of prenatal nutrition and skill in planning and preparing meals increased by 35%; her skill in managing family resources and handling family crises improved by 50%.

Oxford Public Schools, "Pregnant/Parenting Teen Program"

The program is a region-wide program designed to meet the comprehensive physical and developmental needs of pregnant and parenting students residing in seven participating school districts.

Goals: help students continue their education; enable families to support their offspring; to help students achieve a healthy childbirth experience and assume the parenting role; assist students in making further decisions about sexuality, relationships, and career goals; identify a network of local agencies whose services are needed.

Staff: nurse therapist program coordinator; career counseling/student advocate; information developer; two program aides; van driver

Services: Nineteen teens, including 6 handicapped and 11 disadvantaged students received individual, family, and career counseling, and participated in a monthly peer support group; a summer component included home visits.

Outcomes: All students returned to school, with an appropriate course of study, and located day care; a directory of services was compiled and students were enrolled in services they needed; there is evidence that the infants were well cared for as growth and development was measured within normal limits.

Pioneer Valley Regional School District, Student and Family Education Transmits Attitudes, Skills and Knowledge for Success (SAFE TASKS)

The project uses a three faceted approach to improve family communication between students and their parents:

Carl Perkins Act

a. upgrading the home economics curriculum
b. producing and mailing newsletters to families
c. providing evening workshops for students and their parents

Federal funds were used for the salaries of a part-time coordinator secretary, and workshop consultant, and for instructional supplies.

The home economics curriculum was updated to include information on improving communication, responding to crises, nutrition, home management. Teachers received inservice training on these topics. The school district produced and mailed 6 newsletters to 882 families in the district, covering topics such as suicide, child abuse, drug and alcohol abuse, teen parenting, and divorce. The newsletters were designed as a springboard for discussions.

About 20 students and 30 of their family members participated in 8, 2-1/2 hour evening workshops on problem-solving, decision-making, and managing time and money.

The impact of the program was broad-based and community-wide. The multi-faceted approach proved to be effective in increasing family communication in a rural community.

Blue Hills Regional Technical School

In 1986, the program received federal funding for educating adolescent mothers, demonstrating a strong commitment to keeping them in school, teaching parenting skills, and ensuring that they are sufficiently trained in occupational subjects to obtain employment. The program covers a wide region in the state.

The federal grant was $26,000 and was matched by the Blue Hills Regional Vocational School District. In conjunction with the program, Randolph High School launched a program for teen mothers more interested in an academic environment than vocational training. Day care services are located in the high school for teens from local and surrounding areas covered in the vocational region.

The Departments of Welfare and Social Services from the South Shore are involved.

Emphasis is on subjects that promise high employment prospects, including data processing, word processing, graphic communications, clerical skills and health services.

Currently the program is experiencing difficulty with transporting teen mothers and their children from surrounding areas involved in the program, to the day care center at Randolph High School. If transportation is not provided, some teen mothers may be forced to drop out of the program.

History and National Perspective

School-based centers are medical facilities offering an array of health, social services, and mental health services that are located either in a school building, or on the school grounds. Most of the clinics now in operation were initiated at the community level, primarily by persons who were not part of the school system. Many clinics were begun by professionals, community leaders, church leaders, and parent groups who were concerned and wished to confront the ing numbers of teen pregnancies, dropouts, suicides, depressed youth, drug and alcohol use and abuse, and other problems experienced by teens.

School-based centers, or clinics, represent an innovative response to health needs that otherwise would remain untreated. According to an article in "Youth Law News",[363] "although concern over increasing rates of teen pregnancy provided the impetus for the establishment of the first school-based clinic in 1973, experience has shown that the clinics meet with greater acceptance, from students as well as from parents and the community at large, when they address the full range of adolescent health needs, emotional as well as physical."

Many were also concerned about sexually transmitted diseases, and the overall lack of, and inadequacy of, adolescent health care. There was recognition that adolescents, as a group, do not seek health care, nor do they follow through with maintenance of health care. "Whether medical services are provided in doctors' offices, street clinics, emergency rooms, family planning agencies, or university-based hospital outpatient departments, the youth patient has to initiate the request for services herself, or be brought to the provider by a parent or through professional referral. The one exception is school health services. Since almost all adolescents at least start out in school, medical, social, and psychological services can be brought to the client along with daily reinforcement and support."[364]

Joy Dryfoos, in her paper "School-based Clinics: Serving Adolescents Where They Are"[365] states, "an array of services are offered to students of one or more junior and/or senior high schools, ranging from general physical exams and immunizations to prenatal and postnatal services and family planning services. Caseloads vary in size from 500 to 5,000 students, representing one-fourth to three-fourths of the target student bodies. Students may make repeat visits so that the largest programs have the capacity to cover 20,000 clinic encounters a year. A team of doctors, nurse practitioners, and various specialized personnel, such as dental hygienists and nutritionists, are available to staff the clinics. Support services are offered by clinic aides and community workers." Also, teens serviced at the school may receive off-site services at medical and mental health facilities, during periods of time when school is not in session, by staff who may already know their history from working at the school clinic.

As a result of research studies that supported the view that early pregnancy and childbearing is often the result, or product of, low socioeconomic status and the lack of opportunity, "it was proposed that the ordering of interventions associated with pregnancy prevention might need to be transposed; for certain young women and men, amelioration of some aspects of the social environment would have to precede or at least accompany reproductive health care interventions such as sex education and birth control services. This concept was based on the premise that existing pregnancy prevention programs would have little relevance to young people who did not perceive that their lives would be any worse if they became parents."[366]

History

These findings led to the recognition that the schools have a crucial role to play in servicing youth, as the school is the one place that touches the lives of all children. The Dryfoos article points out that the role of the schools could be expanded for pregnancy prevention, along with prevention of other problem-behaviors, "from sites where sex education might be provided, to sites where a very wide range of services should be provided, such as the direct provision of health services including family planning; efforts aimed at improved achievement using innovative techniques and/or alternative schools; and the availability of personal support and guidance."[367] Research acknowledges that schools could not provide the range of "life options" services without outside supportive services, and the practical skills required from linkages with private and public resources. "In anexamination of past efforts to transform public schools into multi-purpose social science institutions, it was suggested that schools were only willing to house non-educational services as long as they were supported from an external source; when sources dry up, schools did not adopt the programs."[368]

According to the Dryfoos article, "while school-based clinics are not the total answer to the life options requirement, they are important entry points into the school systems, they may provide a center from which educational enhancement and social services can be launched, and may foster a case-management or one-on-one approach to ensuring that youngsters will be treated as individuals with equal entitlement."

Agencies and organizations involved with development and implementation of school-based programs have included hospitals and medical schools, community clinics, departments of public health, private non-profit organizations, and family planning clinics. School personnel, however, have usually been involved in the planning and operation of the clinics from their inception.

The Dryfoos article states services provided in school-based clinics:[369]

1. Physical examinations
2. General health care
   minor illnesses
   accidents and injuries
   immunizations
3. Family Planning
   gynecological examinations
   birth control prescription
   pregnancy testing
4. Sexually transmitted diseases diagnosis and treatment
5. Maternity care
   pre- and post-natal care
   well-baby care
6. Mental health screening and counseling
7. Dental screening and services
8. Nutrition and obesity counseling
9. Laboratory testing

History

In collaboration with other school personnel, these services are also offered: health education, sex and family life education, curriculum development, accident prevention, school lunch programs, parenting skills training, and other health and safety issues. Special programs are also offered in the prevention and treatment of drug and alcohol abuse, depression counseling, suicide prevention, child abuse and neglect, and day care for the children of teenagers.

The main focus of school-based clinics is to coordinate services and linkages to community services, teaching hospitals, health and social services, and to focus on prevention and intervention. Their goal is to bring services, in a comprehensive format, to where teens are located and spend much of their lives. The focus is also on drop-out prevention, and in accessing teens to services in a comprehensive, non-threatening, confidential, available setting. Referral services can also be streamlined, and consistent follow-up and monitoring can be maintained.

According to the Boston Student Human Services Collaborative, and other sources, school-based health programs "are developed to improve access and expand health services to underserved poor and minority children and young people. They are satellite or community outreach programs of established health care institutions or organizations that provide back-up and off-hours medical coverage."

School-based programs, as well as community-based and other programs, should be based on a continuum and sequential progression of the developmental stages of children, pre-adolescents, and adolescents, recognizing the varying stages and accompanying needs and problems that each child or youth experiences. These progressions are portrayed on the servicing model chart accompanying this report, as drawn up by the Task Force on Pregnant and Parenting Teenagers. Components of the school-based clinic model are stated in the chart, along with community linkages, networks, and other servicing elements that address the prevention of teen pregnancy and other problem areas. The provision of services and continuity of care to pregnant and parenting teens, and services that address other teen issues and needs, are also stated on the model chart. The chart represents a composite of all servicing elements and program components collected from programs gathered from states across the country. Not every school-based model has all elements and components - each school program has elements and servicing components that are based on community needs, and are reflective of community representation.

Many programs have added, or have initiated at the inception of the clinic, social services and counseling components to help students with communication skills, decision-making and problem-solving skills, self-esteem and self-concept issues, and to aid in early detection of emotional problems and mental illness with at-risk students. Other programs have components and/or support services that deal with life options education, training and counseling. Vocational education, pre-employment and employment skills training and counseling may also be provided, either on-site or through referral mechanisms. Home economics programs, and associated programs, can be incorporated into the school-based centers, and educators can work closely with the staff of the clinics.

History

School-based clinics are defined in terms of broad-based comprehensive, multiservice and interdisciplinary programs. While all programs received and studied for this report state these terms in their definitions and descriptions, there is varied interpretation and application of the terms. Most programs reviewed have an array of core services that can be defined as "comprehensive", and many provide ancillary services, support services, or additional services that are integrated into their core services, or are in addition to their core services. Comprehensive services provided may be defined in terms of those services needed for a particular population, in a particular community, and may reflect the varying moral, ethical, religious, ethnic and cultural beliefs of the community. The range and type of services reflect the social and economic composition, and level of need of the community in which they are located. Availability of resources and how these resources are accessed are also determining factors. These variations in the definition and content of "comprehensive" do not apply only to school-based programming, but to other types of programs located in sites other than schools.

There has always been controversy and conflict over what the proper role of the schools should be in the provision of health care to students. Dryfoos[370] points out that education reformers in the late 19th century attempted to shift the focus from an emphasis on contagious diseases and improvement of school buildings to the treatment of physical defects and amelioration of environmental influences. "School nurses were encouraged to make home visits to advise immigrant families, and it was proposed that school health clinics be organized to conserve and upgrade the quality of health for deprived children."[371]

The idea of providing health services through school clinics is not a new one. It has its strong supporters and equally strong detractors. Members of the medical profession object, either because of economic interest, or they are concerned with the provision of quality care. "Other objections are around the possibility of conflicting jurisdictions, administrative complications, duplication of services, and restriction of school-based services to students and their school schedule.[372] Some feel that the schools should only provide screening services for vision, hearing, and fluoride treatment, or that the schools should only be a link for referral service for other kinds of services.

Dryfoos states that "supporters build their case around the stability of the school system as an institution. The least assailable argument put forth for providing comprehensive health care in schools is probably access, schools are where the children are."

The first conference of administrators, foundation representatives and researchers concerned with school-based clinics was organized in Houston in 1984. The conference was supported by the Ford Foundation, the Center for Population Options, and the Urban Affairs Corporation. The conference was organized by Sharon Lovick, who was administrator for the school-based program in Houston, operated by the Urban Affairs Corporation. The Houston program consists of a central school clinic that serves students from six outlying schools, and is described in the section on national programs.

History

The goals of the conference were:
- to discuss the school-based model and share experiences
- to determine if there was a defineable model or if programs were too varied to be compatible
- to respond to the needs of people across the country who were planning to initiate school-based clinics
- to broaden the base of information about current programs

A conference report is available from the Center for Population Options in Washington, D.C.

"The conference produced an overwhelming confirmation...that there is a school-based clinic model including family planning, offering a range of personal health services to low-income target populations, mostly in inner cities. However, organizational structures are not uniform."[373]

Another report by Joy Dryfoos, "Prevention Strategies: A Progress Report", published in 1985, states, "during this past year, the placement of comprehensive multiservice health centers that include family planning in public schools moved up on the social agenda from a unique experiences to the edges of a social movement."[374] At the time of this research, Dryfoos also states, "the fact that comprehensive health services including family planning are currently offered in 31 clinics in the high schools of 17 very diverse cities is evidence that school systems are willing to become the focus for a broad range of prevention activities... schools are much more open than ever before to receiving outside agencies that will bring in services needed by students in disadvantaged communities." Since this report, there have been nearly 100 community school-based programs established across the country, with currently an equal number in the planning and implementation stages. Many school systems are presently expanding on existing programs. The consensus of current research from a variety of sources is that school-based clinics are viable, cost-effective and popular programs.

Review of Programs Nationwide

The Task Force on Pregnant and Parenting Teenagers has collected reports and information on over 200 programs nationwide. In addition, correspondence and telephone conversations were exchanged with the directors and/or staff persons of many programs across the country. Program directors cooperated with requests from the Task Force for reports, statistical data, follow-up studies, research and evaluation, when such information was available. When follow-up questions were asked of the program directors, or further information was requested, the directors cooperated positively. Programs and information received were reviewed and studied, and are currently on file with the Task Force. The following summaries, descriptions, and effectiveness/evaluation data are taken from reports and information received by the Task Force.

Nationally, school-based health services and programs have been in existence in many parts of the country since the early 1960's. The first school-based clinic formally established in the U.S. was in 1973

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by Dr. Laura Edwards, in St. Paul, Minnesota. The clinic was established in Mechanic Arts High School, under the auspices of St. Paul's Maternal and Infant Care Project.

Though the St. Paul school clinic evolved and developed into a model program for comprehensive school-based health services, and became widely known for it's innovative programming and effectiveness, it was not replicated in significant numbers until the early 1980's. Recently, state legislatures and the federal government have been considering policy initiatives and funding requests to encourage the establishment of school-based clinics.

In 1985, the Oregon legislature allocated $250,000 for comprehensive health clinics on school campuses, making this the first sta in the country to establish a school-based clinic demonstration program. In California, a bill that would provide matching funds for at least three pilot school-based health clinic programs of three years' duration was passed in both houses of the legislature. North Carolina set aside funds in 1985 legislation for "innovative community-based programs and projects such as school-based adolescent health clinics." The state did, however, eliminate some funding for certain services in the clinics. The Connecticut Governor's budget for fiscal year 1986-1987 included $225,000 to expand already existing school-based clinics. These funds were targeted to financing three new clinics, two in urban areas and one in a rural community. Wisconsin appropriated $1 million for teen pregnancy prevention and services programs, including school-based clinics, in 1985-1986, and continuing to date. In 1986, the Robert Wood Johnson Foundation announced that it would fund school-based clinics in up to 20 cities with populations of at least 100,000. Each city selected will receive up to $600,000 over a six year period.

Following the establishment of the St. Paul program, most of the clinics that were initiated started with a similar comprehensive array of services, with many including reduction of teen pregnancy as a primary goal. Several offer drug and alcohol abuse counseling programs and pediatric care for the babies of students. Day care programs have been established in many schools for the children of teen parents who are attending classes. Day care is so far offered in only a small number of the programs, with transportation provided at a few programs. Most school-based clinics are located in low-income urban areas, and services are provided either free of charge, or for a nominal fee.

All of the clinics require some form of parental consent before students can use their services. Most list the services offered on the consent form, and some give parents the option of deleting services they do not want their children to receive. Most clinics have a policy that, once parental consent is given, all services are confidential; students' medical charts are not part of their school records, and no one may have access to a chart without the student's permission. Those planning school-based clinics have generally made great efforts to consult parents at every stage. As a result, parents have been generally supportive of the clinics.

Most programs currently in operation have parent and/or community advisory groups. Directors of the programs state that they have strong support from the school administrators and personnel, from students and

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parents, and from the collaborating agencies and the community as a whole. The consensus of these directors is that, despite some management issues, the staff generally enjoyed working in the school clinics, and were very positive and enthusiastic about working with the adolescents in the various school sites. Many of the staff experienced low pay scales, but turnover in staff was not a problem.

The Center for Population Options, under the direction of Douglas Kirby, has recently published a pamphlet on how to plan and implement school-based clinics. The report, "School-Based Health Clinics" may be obtained by writing:

The Center for Population Options
1012 14th St. N.W. Suite 1200
Washington, D.C. 20005

The above report is discussed in the Dryfoos paper on school-based clinics. Other findings from the report are:

* While there is a model for school-based clinics, including family planning, and offering a range of personal health services available to low income target populations, organizational structures are not uniform:

  - one-half are initiated and managed by an individual in a medical establishment in a university-hospital, medical school setting, or by a city department of Maternal and Child Health (MCH).

  - one-half have been initiated and managed by a diverse group of non-profit organizations such as youth programs, United Way, and local Planned Parenthood affiliates

  -one school-based clinic was organized by a school system

* Those programs operated in university settings have many levels of bureaucracy to contend with, whereas non-profit agencies seem to have more direct management and less bureaucracy. However, agencies often have less resources to fall back on such as physician manpower and data collection mechanisms.

* Of critical importance is the fact that "at the clinic level (most programs have 2-4 sites), the delivery of services does not appear to differ because of organizational structure."

* The size and complexity of programs appear to be the function of the level of financial resources available, which reflects the ingenuity of the program director in putting together comprehensive funding packages.

* School-based clinics are viable, cost-effective, and popular.

* After the first clinic is established in an area, replication at other sites in the same area or nearby areas is easy.

* Decisions concerning the establishment of school-based clinics should rest with local communities and their school systems.

* The conclusion is that school systems, in cooperation with various health care and youth servicing agencies, should further develop and refine comprehensive school-based clinic models for implementation and evaluation in schools with large, high-risk populations.

School-based clinics vary widely in the range of services they offer, funding sources and mechanisms, and organizational base. They all share in the same basic premise, however, and that is, to be effective, health services for adolescents and pre-adolescents must be located where the teens are... in the schools.

It must be noted here that school-based clinics, for the most part, assume that the teen, or pre-teen, is in school. Even a cursory review of the literature on the educational status and dropout rates of vulnerable populations of teenagers, such as pregnant and parenting teenagers, and those who experience school failure, grade retention, family problems, and other such contributing factors, reveals that teens who need these programs the most are often not in school. Many pre-teens and teenagers exhibit truancy, problem-absence and high drop out rates before, during, and after pregnancy and childbirth. Many others experience problem behaviors that would greatly benefit from school-based programs. These behaviors are also highly correlated with substance abuse - either in the youth, his or her siblings, and other family members, family violence, family destabilization, and other social, economic and environmental problems. The questionaires conducted with pregnant and parenting teens in Massachusetts by the Task Force indicate that, from preliminary findings, a large number of pregnant and parenting teens drop out of school before becoming pregnant. This area is a strong point for intervention strategies, and must be carefully considered in any planning for, and implementation of, school-based programs.

In communicating and corresponding with program directors nationally, the question was asked, "do you have any mechanism to retrieve dropouts and problem-absent students?" Some programs stated that they did not have any formal mechanism, but relied on community outreach workers to intervene with these students, and try and return them to school. There is also a category of these teenagers who are not seen by any service providers, school personnel, or community workers. The youth "fall through the cracks" and are often lost to any service or programming interventions. The community workers who did perform outreach services were often not connected to the schools, but were part of a network in the community. These workers may see the youth in their health centers, youth centers, or other such programs, and try to get the youth to return to school. While many programs did have

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dropout prevention as a priority in program development, and these measures would help to keep some youth in school, many youth needing the services the most are already absent, truant, or have dropped out. Formulation of a mechanism to retrieve dropouts and problem-absent youth must be a key component in any school-based program.

Another aspect of school-based programs that creates problems, and one that is a concern stated frequently in the literature on school-based programs, is that the clinics are closed in the summer, and during school vacations. As continuity of care is essential in servicing these populations of youth, this is a critical area that must be addressed in program planning. Also, for many teenagers, the periods of time they spend out of school - weekends, summers, vacations - is often a critical time when family problems, personal and social problems, negative peer influences, and other determining factors, erupt and become accelerated and more volatile. Also, for many health problems or health needs, continuity is a key factor in health maintenance and health promotion - both physical and mental health. While these gaps in continuity may be filled by other community resources to some extent, the structure and accessibility of the school-based program is a positive factor in the continuity of care needed by many teenagers. Further discussion of school attendance and dropout issues is found at the beginning of this section.

The following programs are school-based clinic programs. They were chosen to represent a variety of ways that the programs may be planned and implemented. A brief history of the program, description of services, organizational base, staffing, and other components of the school-based model that are indicative of a particular school district, city, or state, are presented here as they were conveyed to the Task Force by program directors. Research reports and evaluation studies of the programs are used as references.

St. Paul School Health Program: Adolescent Health Services Project - M.C.H. Program at the St. Paul Ramsey Medical Center

Nationally, school-based health services and programs have been in existence in many parts of the country since the early 1960's. The first school-based clinic formally established in Mechanic Arts High School, under the auspices of the St. Paul Maternal and Infant Care Project, in 1973 by Dr. Laura Edwards.

The St. Paul area had been experiencing increasing pregnancy rates and high rates of infant mortality and low birthweight among infants born to teenage mothers. In an attempt to decrease the pregnancy rate and improve the health of the infants, the St. Paul Maternal and Infant Care Project suggested placing a clinic in the high school. Starting with a Maternal and Infant Care Project (MIC) grant to St. Paul Ramsey Hospital in 1968, Dr. Edwards obtained approval from the local school board to offer prenatal and post-partum services to pregnant students in St. Paul's only inner city school. The success of the initial program was founded in follow-up studies which indicated that the babies did have better outcomes, the mothers stayed in school, and the pregnancy rate began to drop.

National Programs

"Initially only prenatal and postpartum services, testing and treatment for sexually transmitted diseases, pregnancy testing, Pap smears, and contraceptive information and counseling were offered. When the clinic staff saw that students were not enrolling in the clinic, they expanded the services to include athletic, job, and college physicals; immunizations; and a weight-control program. These changes proved to be pivotal in the acceptance of the program by parents, faculty, and students."[375]

According to reports received by the Task Force, the purpose of the program is to "improve health and the future well-being of those it serves through direct medical care, educational services, counseling, and preventive health services provided by an interdisciplinary team. Of primary concern and a major focus is to educate students to become well-informed health care consumers and to orient them towards an integrated approach to their overall health and wellness - social, mental, emotional and physical." Efforts of program are directed towards increasing awareness and knowledge of positive health behaviors, as well as promotion of positive changes in lifestyle. The program provides opportunities to learn and practice decision-making and problem-solving skills. In addition, educational programs were tailored to meet the specific needs of target groups within the community and the school. An issue of main concern is to address the impact of all aspects of a person's life on their pregnancy.

The report received from St. Paul stresses the fact that "as accessibility to programs and services was of primary concern to the director, staff, and providers of services, financial and transportation barriers to care were first removed."

The range of services provided at the St. Paul program offers anonymity for the students, who did not want to be labeled as sexually active, and in addition, it offered health services to students for needs that otherwise would remain unmet.

The Maternal and Infant Health Project then started clinics in three additional schools, and services were then expanded to include dental hygiene, nutrition, day care for infants, and family life education programs. Contraceptives are not dispensed at the clinics, but prescriptions are written, and there is a unified referral service system. The staff members maintain close contact with their students to ensure that they understand the use of the birth control method they have selected.

Over the past decade, new components have been added to the St. Paul Program, and new locations have been instituted. A wide range of services, in fully equipped clinics are now offered to all students in four high schools, and in two junior high schools.

The St. Paul program, Maternal and Child Health (MCH) has a threefold purpose:

National Programs

Maternal Care Project - comprehensive prenatal and postpartum services for high risk women; goal is to reduce infant mortality and morbidity and to improve birth outcomes

Child Health - provide primary and preventive health care to infants; up to 18 months after birth care to infants

Adolescent Health Services Project - comprehensive health services that address a variety of adolescent health needs; located in all schools that have clinics; programs and education for elementary and junior high school students

Teen Birth Control Clinic - located in nearby hospital for sessions once a week

The following programs and services are offered in the high school clinics:

Prenatal Education Programs
Parenting classes and support groups
Nutrition/Weight Control/Exercise Programs
Chemical Dependency Support Groups
Assertiveness/Communication Groups
Individual Education in Family Planning
Pregnancy, Parenting, Nutrition
Wide range of other services

The staff of the program have stated that the team approach in school-based clinics is the most desireable staffing arrangement, utilizing the services of a physician, nurse practitioner, dental hygienist, nutritionist, and mental health worker. All school-based clinic programs reviewed appear to use the services of physicians and nurse practitioners in varying combinations as well as social workers and non-professional aides. One evaluation of the program states that the strength of the model lies in the consistency and availability of the staff. The staff also serves as classroom speakers and give seminars in classes. The staff also have well-established linkages with other agencies and programs, and act as a resource and referral service. They also conduct frequent staff conferences concerning targeting behaviors and needs, and certain students may be assigned a risk score.

The staff at St. Paul have identified six components they believe are essential to the basic high school model:[376]

1. A multidisciplinary team of professionals.

2. An indigenous worker or community worker who serves as a broker between the service team and the adolescent.

3. Situation of the clinic on the adolescent's turf.

4. Open door policy; prompt service for appointments; accommodation of walk-in patients

5. Offering family planning as one of a wide range of services; providing anonymity for secually active students.

6. Orientation of staff to flexible, non-bureaucratic approaches.

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All students participating in the services of the clinic are required to have a consent form signed by their parent(s).

The Teen Birth Control Clinic is located at a nearby medical center, where teenagers are provided free and confidential family planning services, education and counseling, medical assessments, follow-up assessments, classes in all areas are conducted.

The Adolescent Health Services Project is funded through Maternal and Child Health Block Grant monies, Title XX funds, and Title XIX reimbursements. The Project also receives donations and contributions, and parents and members of the community conduct fund-raisers. All services of the clinics are free.

Effectiveness Studies and Evaluation

The Project is highly interested in research studies on the effectiveness of the programs. Recent reports state:

* In 1984-1985, 70% of the school population registered for services in the program.

* Over 2,000 students are serviced annually; 1,500 students participated in other classes offered within and outside the schools.

* There were 12,744 student visits to clinical sessions, many of them repeat visits, or follow-up visits.

* 2,500 students participated in the three week program

* Teen pregnancy rates were reduced by 40%; teen pregnancy rates were reduced by 56% since 1976.

* Of those students that were maintained in follow-up studies, contraceptive continuation rates were 90%+ over the past ten years.

* There has been only one repeat pregnancy within 1-2 years of follow-up study.

* Of those students who remained in school, the repeat birth rate was 1.3%.

* 80% of pregnant and parenting students completed high school. 13% dropped out; 7% were unknown to follow-up in a longitudinal study.

* The live birth rates to female students at schools that had clinics in them continued to decline over the ten year period, as follows:

1976-1977	59 per 1,000
1979-1980	21 per 1,000

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1980-1981	30 per 1,000
1982-1983	62.5 per 1,000*
1983-1984	26 per 1,000
1984-1985	37 per 1,000

* According to Wanda Miller, Supervisor of the School Health Program, the reason the birth rates increased to such a large extent in 1982-1983, was due to an influx of Asian immigrants into the city of St. Paul. Ms. Miller stated that, "once we had identified the problem, and the needs of this population, and adapted our programs to meet those needs, the birth rates began to decline again."

Of concern to the staff is that 39% of their students are lost to follow-up studies and monitoring. Also, the problem of the impact of abortions on rate reductions in teen births are difficult to assess, due to the lack of solid abortion data among the female teen population. The staff are aware of these difficulties, and are attempting to resolve these issues.

Ms. Wanda Miller, Supervisor
School Health Program, St. Paul Public Schools
360 Colborne St., St. Paul, Minnesota, 55102
612-293-7686-7

Adolescent Family Life Program

The Adolescent Family Life Demonstration Projects: Program and Evaluation Summaries gives a program description and explains the current demonstration design being conducted on the St. Paul AFL program. The Adolescent Family Life Programs are discussed in a previous section under federally funded programs.

Director: Dr. Laura Edwards, M.D.
Type of Project: care
Model: School-based clinic
Date began: Oct. 1, 1982
Clients Serviced: 1984-1985 at two AFL sites

pregnant teens	41
adolescent mothers	27
infants	23

Program Description: The program at St. Paul is a care project for pregnant and parenting teens, with all services provided in two inner city school-based clinics. These two clinics are part of a total program of adolescent health services in four high school clinics, a hospital-based clinic, and a community youth center.

The clinics are located within the school building and are open during school hours. A comprehensive range of services are provided by a team of medical, nursing, social, nutritional, and educational professionals who work with the school nurse and other school personnel.

The St. Paul Project is testing the hypothesis that providing comprehensive counseling, educational and health services to pregnant

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teens at a regular high school clinic results in better pregnancy outcomes, fewer repeat pregnancies, and greater completion of high school. The results of the program teens are being compared with two control groups. One comparison group is pregnant teens who transfer to an alternative high school; the other comparison group is teens who do not remain in either school but receive health care at the St.Paul Medical Center.

The Project is currently collecting one year of data from 40 matched pregnant and parenting teens at each site and plans to collect one year of data each retrospectively and prospectively.

Project for Austin Teen Health, PATH, Chicago, Illinois

A combined health center and high school program was instituted in Austin High School in Chicago, by Dr. Patricia Langehenning, a physician in Cook County Hospital in adolescent medicine. Dr. Langehenning was motivated to begin the clinic because of the large numbers of teenagers who came to the hospital sick. The clinic is open four mornings a week. During the first year of it's operation, one third of the students in the school had enrolled.

According to Dryfoos,[377] "despite the complexity of the organization and the inadequacy of the arrangements, a small clinic has opened its door within a Chicago public high school to serve a community with the highest rates of teenage pregnancy, infant mortality, and STD's."

Funding was obtained from the RWJ Foundation for this program. Cook County Hospital is the grantee and supplies medical personnel, with Dr. Langehenning and other residents as members of the staff. The Chicago Dept. of Health provides supplies and space for the Center, and the Board of Education provides a room at the school.

DuSable-Bogan Health Clinic, Chicago

The school-based clinic located in DuSable High School in Chicago's south side, was begun in June, 1985, by Patricia Davis-Scott, director of the comprehensive health clinic. This clinic is one of about 17 school-based clinics across the country that distributes contraceptives to students. Counseling sessions focus first on abstinence, and writ parental consent is required before contraceptives are dispensed. The director states that neither abortion nor abortion counseling is carried out at the clinic. Students must also be free from drugs, tobacco, and alcohol use before using the services of the clinic.

The clinic is located in one of the country's poorest areas, with unemployment rates of 22% - the national rate is 7%. The majority of the students come from local public housing developments, and 79% of them live below the poverty level.

Davis-Scott is a registered nurse, and also directs a similar clinic at Orr High School on the west side. This area also has high rates of teen pregnancy and infant mortality, and low rates of income.

The clinic offered ten health services to students, most of whom could not afford health care. The clinic exists, rent-free, in the high school, but is a separate entity funded by the Illinois Department

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of Public Aid and private foundations.

In September, 1985, thirteen black clergymen from the south side, some parents, and an anti-abortion group filed a lawsuit in an attempt to stop the distribution of contraceptives at the school clinic. The clinic itself was not a defendant, but charges were brought against the Dept. of Public Aid, School Board, and the principal of the high school. Charges were as follows:

* violation of students' privacy because of the questions about sexual activity
* failure to warn parents of the risks involved in the use of certain birth control devices
* invasion of parents' rights to instruct their children
* violation of a Supreme Court ruling requiring school neutrality on issues involving religion (use of contraceptives being opposed in some religious beliefs)
* the clinic program was designed to control the black population

The School Board convened a hearing, where most of the parents, students, and local community leaders and interested persons stated their strong support for the clinic. Most of those who attended in opposition to the clinic came from outside the area in which the clinic was located. The clinic continued it's operation with no change in services.

By the first 16 months of operation, more than 14,400 visits were made to the clinic. Approximately 12,400 were made for physicals, immunizations, first aid, and other medical services. About 14% of the visits were made for contraceptives or for counseling on sexual activity.

Dunbar High School, Lombard Junior High School, Baltimore, Maryland, Johns Hopkins University

The school-based clinic programs were initiated in 1981. The program consisted of in-school counseling, which gave senior and junior high school students birth control information, advice and free contraceptives. Counselors told students first to regrain from sexual activity, but to use birth control if they did become sexually active. Rosalie Streett, Director of the Student Clinic stated, "counsel told students to say no, and that if they didn't say no, to use contraceptives."

Two social workers, a nurse midwife, and a nurse practitioner were available in the schools to answer questions and provide counseling to interested students. They also referred students to a nearby clinic, where family planning services staff dispensed free contraceptives.

The Johns Hopkins Adolescent Pregnancy Prevention Program, The Self Center, located in Baltimore, is directed by Janet Hardy, Professor of Pediatrics. In a letter to Representative Fiero, Professor Hardy

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stated that components were added to the programs that stressed psychosocial support and health and parenting education; individual case management, and that "utilization of needed resources through referral to an extensive network of community services have been important to the programs' success." Prof. Hardy also stated that sizeable medical care costs were averted through the programs. In addition to the in-school services, youth received services in a store-front clinic located close to the schools.

The two schools combined research and demonstration programs that provided family life education and counseling in the schools, and additional counseling and education, along with reproductive health services at a nearby clinic. The school and clinics were located in "high-risk" areas in Baltimore.

The research study consisted of comparing students in the two programs with students in two otherwise similar schools that were not part of the program. Results are:

- pregnancy rates among students in the program declined by about 30%, as compared to a 58% increase in pregnancy rates among students not in the program

- there was a significant improvement in clinic attendance and contraceptive practice among sexually active teens

- students in the program for three years postponed first intercourse about 7 months longer than students not in the program

- before the program, 13.5% of the sexually active girls at the schools became pregnant; the rate dropped to 11.5%

- the median age for beginning sexual activity was 15.7 years before the program, and 16.2 years after the program

Laurie Zabin, who presented a report to the American Public Health Association on the programs stated, "the reduction, while small, was a major achievement because it came at a time when the pregnancy rate among teenagers in Baltimore was increasing." She also stated that even though other studies have shown that family planning services do not encourage sexual activity, the evaluation team was surprised to find that the program appeared to delay the onset of sexual activity.

The study results point to the conditions of abject poverty that must be addressed, with the resulting lack of jobs and education. Long-term follow-up and maintenance is a necessity in the tracking and monitoring of the teenagers needs and behaviors. The study states that at least three years of these post-program services are required, in order for programming to be effective.

New York, New York

In 1984, Governor Mario Cuomo introduced a comprehensive, statewide initiative to address the continuing problem of adolescent pregnancy in New York State.

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According to written communication from the New York Council on Children and Families, "this initiative reflects a commitment to increased primary prevention services and services to enhance self-sufficiency as a strategy for reducing the high rates of adolescent pregnancy and its consequences."

To accomplish these aims, the Governor outlined a plan with two major components: the Governor's Task Force on Adolescent Pregnancy and a new $5 million funding program. The Council on Children and Families is responsible for the coordination of both components of the initiative. The $5 million allocated was in addition to the $20 million already appropriated by the state for adolescent pregnancy programs. The Task Force has issued reports, "Setting Directions" and "Moving Forward: Next Steps". A complete description of the programs are in Section 7.

Under the section on education, one of the primary recommendations is that, "the number of school-based clinics providing a full range of health services, including reproductive health care, should be increased." The report states, "a crucial component of a youth and family development strategy is the provision of basic health care and nutrition services. These services should be available to all youth and should be accessible, affordable, and relevant to their particular needs." Suggested services include screening and referral,comprehensive physical exams, management of minor problems, and follow-up; they are provided on-site in selected schools across the state." The report cites studies done by the RWJ Foundation and the Center for Population Options that "evaluations of school-based clinics indicate that improved health care does result from such programs, even for those youth who have a private physician. And, where school-based clinics in high schools include reproductive health care in their services, fertility rates drop and the dropout rates among adolescent mothers decrease." The report also recommends mandated family life education and increased availability of school-based child care services.

In June, 1984, the New York City Board of Education approved the opening of 8 school-based clinics in the city, with a $1.5 million grant from the New York Health Department. The clinics provide a full range of health services. Parental consent forms asked parents to give permission for their children to receive "comprehensive adolescent health care" at the clinics.

In April, 1986, the Adolescent Pregnancy Interagency Council, issued a report, "Adolescent Pregnancy and Parenting in New York City". Recommendations included a need for the research and evaluation of a variety of models of comprehensive preventive health programs serving teenagers.

In October, 1986, a controversy erupted in New York City over the fact that contraceptives were being dispensed with parental consent in one of the school clinics. In a 5-2 decision, the Board of Education voted to keep the clinics open. New parental consent forms were drawn up that specified what services are available at the clinics.

Many other school-based clinics have been established across the country, either at the local level, or at the state level. California, Wisconsin, Texas, Mississippi, Kansas, Connecticut, and many other states have either established school-based centers in the past few years, or are currently in the process of implementing these programs.

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In 1983-1984, Comprehensive Health Services for youth were established in two high schools and one junior high school in Bridgeport, Connecticut. The objectives of the programs, according to a report received from the administrator of the programs, is "to provide easy access to adolescents for comprehensive health services, including personal and confidential health care offered by the health center staff, who work in conjunction with school nurses, community health clinics, local hospitals and community resources." Parental permission to participate in the program is required. Services to students include immunizations, job physicals, weight control assistance, STD referrals, skin care, prenatal counseling and referral, family life/sex education, personal health counseling, and general pregnancy prevention information. The social workers counsel students and links them with needed services. Group sessions are held. Outreach and case management are essential components to the programs.

Several community and health agencies are involved in the Teen Center Program. Bridgeport Hospital provides the medical component of the program, the YWCA does the same for the social worker. Over 250 pupils were served the first year.

Costs and Funding

The conference discussed in Dryfoos' paper[378] established "rule of thumb" costs for youth to be serviced in school-based clinics, and for operational costs for the clinics. Assuming that approximately one-half of the students in a high school enroll in the clinic, the cost per patient per year is about $100, or about $100,000 for a typical high school. Others estimate costs that range from $150 to $250 per student per year, or from $90,000 to $150,000 a year in total costs for the full operation of a typical high school clinic.

Other cost figures are crude, and are taken from a composite of the range of costs given by school-based clinics established across the country. Some estimate that costs range from about $50 a visit that includes family planning, to $250 a year for a full year of student care. Annual costs are reported as starting at $150,000 for a part-time clinic, to $1.9 million for a program providing maternity services and 3 or 4 clinic sites. Reports from the Children's Defense Fund states that clinics cost $100 a year for each student for comprehensive care.

An administrator from the St. Paul clinic estimates that costs range from $100,000 to $125,000 a year for operation of a full time high school clinic, even after it has been equipped. Administrators of programs in California state that it costs about $2,000 for each enrollee.

Some clinics charge annual fees, ranging from $5.00 to $25.00, either because they need the revenue, or they philosophically support the idea of "fee for services".

An article in Youth Law News [379] states, "to the extent that they are able to deliver preventive health care, including reducing teen birth and school dropout rates, proponents argue that the clinics have the potential to be extremely cost-effective." Another report states, "school-based clinics are cost-effective, since such centers help in the prevention of costly health care, the negative consequences of teen pregnancy, substance abuse, and other problems, they provide

Costs and Funding

prenatal care and other health care, they avert costs of emergency care, reduce dependency on social and welfare programs, maintain youth in school, and promote improved health and mental health, as well as education completion. They can help in promoting youth self-sufficiency and independence."[380]

Funding

School-based clinics are funded through a variety of ways and sources, by a combination of public and private funds. Clinic administrators and directors piece together financial support from a range of sources in order to plan and implement comprehensive services in one location. However, these types of funding sources "tend to be short-term and institutionalizing their base of support is one of the greatest challenges facing clinics." Long-term funding sources are a major concern.

An article in State Government News, "School-Based Clinics Offer Controversial Remedy" states, "the average clinic gets about 64% of it's funding from public sources - state government provides about 16%, federal grants and entitlement programs provide about 48%. About 36% comes from foundations, corporations, and non-profit organizations. Patient fees provide about 2% of funding of the clinics. Some clinics charge a nominal fee, as it is felt that clients prefer to pay something, rather than be "charity cases". Voluntary donations, gifts, and donations make up the rest of the financial support for clinics. Some communities conduct fundraisers. In-kind donations help to defray some expenses.[381]

Many sources of public categorical and reimbursement mechanisms have been tapped for school-based clinics. Public support comes primarily from state Maternal and Child Health Block Grants. Other sources consist of Title X of the Public Health Services Act, which covers family planning. Medicaid and the EPSDT programs are also sources of funding. Social Services funding through Title XX has been used in some clinics for day care services. Dryfoos points out that Maternal and Child Health (MCH) funds are being utilized and are accessible. State education funds have not yet been tapped, but may be potential sources of funding.

Foundation grants have been particularly important in the funding of school-based centers - national funds for start-ups and local grants for special project grants such as outreach, health education components, family planning, drug and alcohol abuse treatment, and mental health services.

The Ford Foundation is currently supporting a major multi-year evaluation of school-based clinics to study their impact on fertility, health, and education. The Robert Wood Johnson Foundation, under the School-Based Adolescent Health Care Program, is currently providing grants to hospitals, neighborhood health centers, health departments, and other qualified medical providers, to develop school-based clinics. Up to 20 cities across the country, with populations of 100,000 people or more, will receive grants of up to $600,000 each over a six year period. The first series of grants were made in June of 1987, the second series will be made in January of 1988.

Family Planning Services

School-based clinics are multiservice, interdisciplinary, and comprehensive, and offer a full range of services. A portion of clinic services are aimed at the provision of family planning services to teenagers. Contraceptive services, and how they are provided, are only one component of school-based clinics.

The question of family planning services, their implementation in the range of services provided, and at what level they will be implemented, is usually viewed from a local perspective.[382] "Clinic policies concerning birth control are often consistent with other policies and treatments. If they write prescriptions for other medications, they generally write prescriptions for contraceptives; if they dispense other medications, they typically dispense contraceptives."[383] Current available data for 62 clinics nationally indicates that about 52% prescribe contraceptives, 28% actually dispense them, and 20% refer patients to family planning agencies.

The panel that convened to study teen pregnancy, and published the report of their findings, Risking the Future, recommends two model programs for providing contraceptive services to adolescents:[384]

1. School-based clinics that provide teenagers with contraceptive services in the context of comprehensive care have the potential to reach a large number of boys and girls under age 18; teenagers are more available for outreach and follow-up.
2. Condom distribution programs aimed specifically at young men represent another potentially promising means of encouraging male involvement in pregnancy prevention.

School-based clinics, coupled and linked with community resources and services, complement sexuality education courses existing in school programs. It has been documented that sexuality education classes, and "free-standing" services, of themselves, do not reduce teen pregnancy rates, or prevent pregnancy and other adolescent problems. While knowledge-based curricula do inform and educate youth, they are not enough, as information is not always transferred to practical reality, especially in the lifestyles of most adolescents. Teenagers do not always know how and when to apply knowledge learned, and often need practical application of the learning they have acquired.

Programs that offer family planning services as part of the service delivery system design may have provoked much discussion and controversy before the programs were instituted. However, parental consents have been obtained without difficulty, and no controversy has been engendered after the program was implemented.[385]

Effectiveness Studies

Many school-based programs have conducted research and effectiveness studies and evaluations on the outcome of their programs, either relying on their internal evaluations, or on outside evaluation studies.

Dryfoos states that SBC's "improve coordination of services, reduce fragmentation, and costly, overlapping services. SBC's provide services and a center from which educational attainment and social services can be launched and may foster a case management or one-on-one approach to insuring that youth will be treated as individuals

with equal entitlement. SBC's also fill in gaps in programming and reduce disparities and inequities that exist among poor and minority youth. Programs attack problems at the root source and provide early detection, screening, intervention, and prevention strategies. They also help with maintenance and monitoring of good health and behavior practices." 386

An article in Youth Law News states that school-based clinics can reduce rates in teen pregnancy by 35-65%; decrease dropout rates by 25-45%; reduce rates of sexual activity; reduce incidences of sexually transmitted diseases, crucial now with the threat of AIDS; reduce rates of substance use and abuse by 40-75%, and reduce teen suicide rates.387

Results achieved at St. Paul programs have been stated in this report. In Kansas City, about 70% of the students use the clinic each year. In Dallas, more than 3,200 students are treated in 11,000 clinic visits each year. The West Dallas Youth Clinic, in a study of nine years of operation, reports a 25% reduction in teen births and close to a 90% reduction in infant mortality. The Johns Hopkins studies in Baltimore indicate that students in the program for three years postponed first intercourse about seven months longer than students not in the program. The pregnancy rate among students in the program declined by 30%, as compared to a 58% increase in the pregnancy rate among students not in the program.388

Many programs report early detection of previously undiagnosed health problems, including scoliosis, anemia, and ear infections. Many students seek help for emotional and family problems.

Kansas City programs, along with many others, report that student absenteeism rates greatly declined after school-based programs were implemented.

Laura Zabin, in a study, states, "school-site satellite health programs improve general health and school attendance, as well as lowering pregnancy rates, reach and engage youth people who otherwise would not participate in programs or receive health services, teach young people to use the health care system, reduce hospitalization care and rates and health care costs, and reduce school dropout rates."389

Massachusetts

In April of 1987, the New England Conference on School-Based Clinics was held in western Massachusetts, chaired by Judity Gorbach of the Department of Public Health, Adolescent Health.

According to the Conference report, the goals of the conference were:

to explore the purpose and uniqueness of School-Based Clinics

to provide support and assistance to new, developing, and established School-Based Clinics

to explore the benefits of addressing adolescent health needs through School-Based Clinics

The Conference reports states, "development of school-based clinics in Massachusetts is emanating from the local communities rather than from state agency initiatives. With the exception of special funding from the Department of Public Welfare, which was contracted to Holyoke after the clinic began, there has been no commitment of state or federal dollars to school-based clinics in Massachusetts."

There are currently in the state, two school-based clinics in full operation, Holyoke and Somerville, both requiring parental consent for students to participate in services of the clinics.

There are many school-based programs in Massachusetts, some implemented by local initiatives, others contracted through state agencies, such as the Department of Social Services Young Parents Initiative, and the Department of Mental Health school-based consultation and/or treatment programs. Some of these programs are adaptations of school-based centers; others offer services extended from another site, and based in schools across the state. These programs are described in the Massachusetts Directory of programs, and are listed in the Education Section, Section 13.

Holyoke

The Holyoke Teen Clinic, Inc. is located in Holyoke High School, and was established in 1985. Plans for the clinic arose from the concerns of the Holyoke Pediatric Associates, from Betty Bradley, a health educator in the high school, and the Superintendent of Schools, George Counter. Concerns centered around the fact that adolescents' health needs were not being met through available services. Community physicians were not seeing teenagers in their practices, nor in local health centers. Betty Bradley organized and coordinated the clinic. The Clinic is a member of the Holyoke System for Pregnant and Parenting Teens, and provides primary health care and counseling.

According to the survey received by the Task Force, the Clinic offers a comprehensive range of services: physical exams, sports physicals; treatment for illness; some lab tests and immunizations; counseling on personal hygiene, sexuality, alcohol and drug abuse; family and relationship issues; medical and counseling services for pregnant and parenting teenagers; family planning counseling. Prenatal

Holyoke

services are received from Providence Hospital Prenatal Clinic through referral. The Holyoke/Chicopee Area Mental Health Clinic provides services to students on alcohol abuse, anger, depression, relationship and family problems. The Clinic has close associations and network systems with the Holyoke Pediatric Association, Holyoke Health Center, Community Adolescent Resource and Education Center-CARE, of the Holyoke-Chicopee Area Health Resources, Inc., V.N.A., Holyoke Board of Health, Family Planning, and is a member of the Infant Mortality Task Force, and CHANS-Holyoke Adolescent Needs and Services.

Funding sources consist of the Dept. of Public Welfare, 3rd party; billing done by individual agencies; insurance; no student is denied services due to inability to pay, or inadequate insurance coverage.

Clinic hours are Monday through Friday, during school hours.

The Holyoke Teen Clinic does not dispense contraceptives, nor does the staff write prescriptions. Students requiring such services are referred to nearby family planning agencies.

Total encounters with students needing services in 1986 were 2,650. The Clinic services 40-50 pregnant teenagers each year, and 25-30 teen parents each year.

Somerville

In the fall of 1987, Somerville High School established a school-based clinic, called Teen Connection. Somerville Hospital offers Health Services for teens at the Somerville Comprehensive High School.

Services offered at the clinic include: physical examinations; illness visits; well adolescent care; health education and information; immunizations; sports medicine; diet education and counseling; lab and pregnancy tests; gynecological care; testing and treatment for sexually transmitted diseases; family planning counseling, including abstinence counseling; counseling for drug, alcohol, smoking, emotional problems. Services are confidential. Insurance plans are billed, or services are free. Parental consent to services forms are required.

Clinic hours are after school, 2:30 to 6:00, Monday through Friday. Plans are to extend clinic hours through the school day.

The school-based clinic was established through a $60,000 grant from the Boston Foundation to Somerville Hospital.

Comprehensive primary care services are offered by a multi-disciplinary team of doctors, nurse practitioners, a bilingual health assistant, and a social worker.

Other school-based clinic initiatives are in the planning stages in Cambridge, Worcester, Springfield, and Chelsea.

In 1986-1987, a proposal was developed by the Boston Student Human Services Collaborative and the Adolescent Issues Task Force, in Boston, to plan and implement comprehensive school-based health programs. The proposal was targeted to at-risk middle and high school students. School sites would have been selected through an open process, by any

interested middle or high school. Parental consent for students to participate in services would have been required. Part of the proposal involved placing family planning services, with contraceptives to be dispensed at the clinics, within the framework of comprehensive services.

While there was widespread support for the plans and proposals, they were not passed, after much controversy and conflict. As an alternative plan, Superintendent Wilson proposed a pilot clinic to be established in one high school that would prescribe, but not dispense contraceptives. Other proposals involved establishing student services offices in schools, with referrals to neighborhood health centers.

The Conference report also discusses school-based clinic initiatives in other parts of New England. New Hampshire is in it's early stages. The Bureau of Maternal and Child Health is working to increase awareness in the community about the health needs of teenagers, and the necessity of developing new strategies to meet these needs, including school-based clinics, and programs. Vermont has used nurse practitioners to deliver primary health care. Maine, using school nurses, has begun to offer expanded care in the schools. Rhode Island offers services to pregnant and parenting students, including case management and comprehensive care. In Connecticut, the Department of Health Services worked with state legislators to pass legislation and funding for school-based clinics. The Connecticut school-based clinics are discussed previously in this section.

While not all states are using Medicaid reimbursements, these funds are available, and are being used by some programs in other states.

New England Conference on School-Based Clinics, Conference Proceedings, April, 1987.

Sexual Activity

In the United States, 50-60% of all young people between the ages of 15 and 19 are sexually active.[390] Some estimates are as high as 70% of 16-19 year olds are sexually active.[391] Some studies indicate that these numbers are even higher in highly concentrated inner city areas. Of all teenagers 13-17 years, 3.5 million males and 2 million females are sexually active.[392] For ages 13-19 years, estimates are that there are 7 million sexually active male adolescents, and 5 million sexually active female adolescents in the United States.[393] Of the 15 million teens who are not sexually active, estimates are that over one-half will become sexually active by the time they reach age 20 years. From research at Johns Hopkins University, Social Research Institute, results of a survey study done with teenage women show that one out of every five 15 year olds admitted to being sexually active; 1/3 of all 16 year olds admitted sexual activity, and 43% of all 17 year olds admitted to being sexually active.

Sexual activity among teenagers up to 19 years increased by two-thirds between 1970 and 1980.[394] Teenage males and females are maturing sexually at an earlier age. The age of sexual maturity is held at between 12 and 12-1/2 years old.[395]

There are studies indicating that there is some relationship between the educational attainment of teenagers and their sexual activity. "The lower the educational attainment of teen girls and their mothers and sisters, the more sexually active they are. Lower educational goals and poor educational achievement are positively associated with sexual activity among teen boys."[396] Several studies suggest that teens from single parent families are more likely to be sexually active.[397] Sexual activity is also related to values of independence and achievement. "High school students who value independence highly but have low expectations for achievement are more likely to be sexually active than their peers.[398] Those with lower grade point averages are more likely to be sexually active. For males, an improved sense of self-esteem is associated with the initiation of sexual activity.[399] For both males and females, those who are sexually active are more inclined to have lower aspirations than their non-sexually active peers.[400]

There are also relationships between sexual activity and other risk-taking behaviors - those who are sexually active are also likely to use marijuana and alcohol more frequently.[401] Non-risk-taking behavior is positively associated with reduced sexual activity.

Adolescent Behavior, Peer, Family, and Media Influences

Adolescents are risk-takers, and do not perceive the consequences of their behaviors. Teenagers are under continuous pressures and influences to become sexually active, often accompanied by irresponsible, immature, and premature behavior.

Adolescents receive conflicting messages, inaccurate and inadequate information, and often have faulty perceptions about human sexuality from the media, from peers, parents, and from society.

Teenagers often perceive themselves as invincible and think that "bad things happen", but not to them. According to an article in "Youth Law News" on teenage pregnancy[402] "discussion of the 'issue' of teen pregnancy is prevalent in the media. However, public acknowledgement and discussion of teen sexuality has not accompanied the recognition

of teen pregnancy. Consequently, admitting sexuality may be seen by teens as less acceptable than having a baby."

Many studies suggest that if communication about sexuality within families was improved, irresponsible sexual behavior and unwanted pregnancies could be reduced. When asked what their sources of information about sexuality in one study, 37% of the teenagers stated that they were influenced by peers; 22% stated literature; 17% said their mothers; 15% said their fathers; 8% were from another source.[403]

In a study conducted by researchers at Johns Hopkins University,[404] on the influence of peers and families on sexual behavior, contraceptive use and pregnancy experience, results showed that teenagers whose views resembled that of their parents had low levels of premarital sexual experience; those resembling their friends' views had high levels of premarital sexual experience. Many of these teens were frequent users of contraceptives, but few had consistent use. Also, the sexual behavior of adolescents is generally consistent with that of their peers, and that peers are a more likely source of contraceptive information than parents for most teenagers.

The direct influence of family factors are important in the decision-making of teenagers. According to the National Research Council, "the greater the parental involvement, the less likely teens are to be sexually active. The more strained and limited the parental involvement and parent-child communication is, the more likely to be sexually active are both boys and girls. Adolescent girls whose parents exert supervision of their dating behaviors report less sexual activity. For many boys, high peer involvement tends to override the effects of parental involvement."[405] Sexual activity among teenagers often occurs long before the teen's personal acceptance of him- or herself as a sexual being; consequently, the average teen is sexually active long before seeking advice and protection.

The Center for Population Options estimates that an average television viewer sees 9,230 scense of suggested sexual intercourse, sexual comment, or innuendo during the course of a year. Yet, references to birth control are rare.

"Teenagers watch about 24 hours of TV each week. By the time they graduate from high school, they have spent more time watching TV than being in school."[406] Teenagers also listen to the radio for approximately 21 hours each week. In a survey of 1,400 parents of children ages 3-11 years, TV ranked second only to parents as the primary source of their children's learning. Another report states that "media ranks third, behind peers and parents, in influencing the values and behaviors of teens. This represents a dramatic shift since 1960 when the media ranked eighth behind such factors as teachers, relatives, and religious leaders."[407] Still another report states that TV portrays six times more extramarital sex than sex between spouses. About 94% of the sexual encounters on soap operas are between people not married to each other. Much of the research states that the media influence is one that propels still-immature pre-adolescents and adolescents toward precocious sexuality, and that premarital sex appears to youth as now being "conventional".

Some studies project the sense that the message to teenagers from the media is a double standard, and creates ambivalence and confusion in teenagers. The message they perceive is that unprotected sex is bad, but that sex should be sought after and pursued. In part, this message may be reinforced by parents who have difficulties admitting that their teenagers are sexually active.

According to the author of "Nobody's Baby: The Politics of Adolescent Pregnancy", "the major changes in decision-making of young women are relative to the connection between marriage and motherhood as selective changes in the larger social environment regarding sexual activity, contraceptive use, and abortion. Adolescents have not necessarily become less moral in recent years. They have been growing up in a world that presents them with different choices than previous generations, which therefore encourages new behaviors."[408]

Birth Control and Contraceptive Practices

According to the Guttmacher Institute, "teenagers know dangerously little about contraception and conception. Forty-one percent of unmarried teens who have never used contraception reported not using it because they thought they could not become pregnant." In another survey, only four in ten teenagers know when a young woman can become pregnant.

Accompanying the rise in the numbers of teenagers who have become sexually active, have been the increasing numbers of teenagers who become pregnant. However, increased and more consistent use of contraceptives has not kept pace with this increase. While accessibility and availability of birth control has expanded, many teenagers become sexually active for many months before ever using contraceptives; many, in the meantime, become pregnant. According to recent research studies, the average teenager waits from between 12 to 17 months before using any contraceptives at all, or seeking any advice.[409]

In one high school survey,[410] 27% said they never used any method of birth control; 39% said they sometimes used a method of birth control; 34% said they consistently used a method of birth control.

Studies indicate that more teenagers are practicing contraception, and are doing so more consistently, and earlier than they were previously. However, these same studies indicate that they are increasingly using ineffective methods. "Most teenagers, approximately two-thirds, don't use even ineffective methods of birth control on a regular basis, or never use any method at all."

The reasons given by teenagers themselves for inconsistent use or lack of use of contraception suggest that family planning clinics, along with education, hold part of the answer to the problem. When asked why they had delayed seeking birth control, many said they just didn't get around to it; others said they feared that their families would learn of the visit. The survey indicated that teenagers experience a large amount of misinformation and fear, and these are the factors that often deter them from seeking contraception services and advice.

In 1984, participants in the MAPPS study were asked about their use of contraceptives. Of those responding, 8.7% stated that they always use contraceptives; 28.6% stated that they sometimes used them; and 62.8% stated that they never used contraceptives.

Public Opinion Polls

Results from a Harris Poll conducted nationwide in August, 1985, indicate that 84% of parents interviewed stated that they think teenage pregnancy is a serious problem; 64% of the parents believe they have little or no control over teenage sexual activity; 52% of the parents believe that parental consent should be required for teens to receive health services, treatment, prescriptions, etc.; 87% of the parents supported sex education in the schools; 69% favored school links with family planning services. The survey also stated that only 10% of the nation's school-age children and youth receive comprehensive health education and services. In a 1985 survey conducted by an independent survey agency by Time, Inc., 78% of those surveyed favored sex education in the schools, including information on birth control.

Public opinion polls taken by the Center for Population Options and the National Association of Broadcasters[411] indicate that 80% of adults support the use of public service announcements and 75% support the use of television news broadcasts to disseminate information about birth control.

Sexually Transmitted Diseases

In the United States, the incidence of sexually transmitted diseases has risen so dramatically that between 1960 and 1980, reported gonorrhea cases increased 122% for 20-24 year olds, 200% for 15-19 year olds, and 163% for 10-14 year olds.[412]

Recent nationwide reports reflect concern over "an epidemic of sexually transmitted diseases that now threatens the health and well-being of millions of adolescents."[413] And, from another report, "sexually transmitted diseases present a greater health risk than ever, as new diseases with high morbidity and mortality threaten young people."[414]

Over one million teenage women a year contract chlamydia, the "fastest growing sexually transmitted disease, and the leading cause of infertility and infant pneumonia."[415]

In the U.S., 1 out of 7 teens contract sexually transmitted diseases. Teenagers make up 1% of AIDS cases, and face increased risks of acquiring the disease as it spreads from drug abusers and bisexuals to their sex partners and on to others.[416]

The Child Welfare League of America has formed the National Task Force on AIDS and Children. In a report, the Task Force cited figures from the U.S. Center for Disease Control, in the fall of 1987. There are 595 cases of AIDS diagnosed nationwide in children 13 and under. For adolescents 13-19, there were 148 cases of AIDS as of June, 1987.

In a testimony before the House Select Committee on Children, Youth, and Families, the Surgeon General, C. Everett Koop, stated, "teenagers, 70% of whom are sexually active by age 19, have the highest rates of sexually transmitted diseases (STD's) among all heterosexuals, and as a group, do not take the threat of AIDS seriously."

Dr. Maryann Shafer, a professor of pediatrics at the University of California, among others, has stated that "sexually active adolescents have become an important population to target intensive prevention programs now."

At a conference sponsored by the Department of Education and the Department of Public Health, a survey of 16-19 year olds was cited.

Results of the survey stated that 70% of teens are sexually active, but only 15% report changing their behaviors to minimize the risk of contracting AIDS - of those who did, only 5% used effective methods.

In Massachusetts, in 1980, there were 10,795 cases of gonorrhea for all age groups. Children ages 0-14 years accounted for 68 cases, and adolescents ages 15-19 accounted for 1,988 cases. In 1984, children ages 0-14 accounted for an increase to 102 cases, or 1% of all cases, and adolescents accounted for 1,844, or 19% of all cases. In 1980, there were 318 cases of syphillis in all age groups. There were no cases for children ages 0-14 years. Adolescents, ages 15-19 accounted for 13 cases. In 1984, while the total number of cases declined to 294, adolescents ages 15-19 accounted for 30 cases, or 10% of the total number of cases for that year.

Family Life and Sex Education Programs

There are currently about 465,000 male and female teenagers, ages 15-19 in Massachusetts. There are another 376,500 children and pre-teens, ages 10-14 years following along behind them.

While high-risk teenagers must be targeted for programs and education, all teenagers need sound, accurate, and comprehensive guidance, instruction, and support services in the areas of human growth and development, informed decisionmaking, communication, interpersonal relationships, and informed choices about life options, opportunities, and their life experiences. Teenagers, and those approaching teen years need incentives and practical support to help them determine goals, and achieve these goals.

Children, pre-teens, and teenagers need uniform accessibility to systematic, consistent education programs that promote and enhance knowledge and learning about human sexuality, responsible behavior in all areas of their lives, self-esteem building, and support from parents, educators, and servicing systems, to help them become positive participating members of society.

Many programs nationally have addressed prevention of teen pregnancy, teen sexual activity, STD's, sexual abuse and exploitation, in the context of sexuality education, and family life education, many for many years.

Sexuality education programs range from classes in basic anatomy to comprehensive family life education. There has been a widespread expansion of sexuality programs to family life education programs, which incorporate self-esteem building, development of interpersonal, communication, and decision-making skills, familial and societal roles, sex role stereotype reduction, life options, and other components.

The threat of AIDS, increasing teen pregnancy, the rates of teen births and abortions, and other factors have forced parents, schools, and others involved, to confront the sexual behaviors and other risk-taking behaviors in teens. Many programs now extend from kindergarten and pre-kindergarten through the 12th grade, are extended throughout the year rather than in short-term seminars, and are based on developmental psychology, emphasize assertiveness training, the mechanisms of decision-making, and students may be assigned essays on topics such as sex in the media.

Currently over 40 states have a strong written policy expressly addressing family life, human sexuality and education, and program outlines and guidelines of implementation.[417] Only six states have no expressly written policy. Many of these states with state policies and legislation, and a written commitment to children and youth, were initiated 10-20 years ago, and have since been expanded and updated. Many have been amended to be consistent with today's societal concerns and health issues. By the late 1970's, policies and state legislation began to address the need to provide young people with straightforward information to help them understand their sexuality, the integration of human sexuality, growth and development into their self-definition, and to help them behave responsibly in society.

Either explicitly or implicitly, all state policies on sexuality education, family life education, health education, acknowledge that parents have the primary responsibility for providing such instruction, and that community leaders, parents, community church groups and leaders, schools, and others, along with the youth themselves, have an important role to play in this vital and critical area of children's lives.

According to the National Research Council, "while schools across the country demonstrate strong agreement on the goals of sex education, they differ somewhat in the content and comprehensiveness of their programs." One study reports that 94% of school districts agree that a major goal is to promote rational and informed decision-making about sexuality; 77% agree that a goal is to increase a student's knowledge of reproduction; 25% report that a goal is to reduce the sexual activity of teenagers; and 21% say that a goal is to reduce teenage childbearing.[418]

The Council also points out that most schools offer short programs, 10 hours or less, that focus on the basics of anatomy, human reproduction, and physical and psychological changes during puberty; they are often integrated with other courses, such as health or physical education. Very few schools offer comprehensive programs of more than 40 hours, and even in schools that do offer comprehensive programs, not all students take the courses. About 80% of school youth receive some kind of sexuality education. However, only 10% receive comprehensive programming and education about human sexuality and growth and development, according to Harris Polls.

In a 1982 survey of 200 cities in large school districts in the country, sex education was provided by 80% of the districts and 85% of the students receive some sex education. Sex education is often offered through another course - only 16% of senior high schools and 11% of junior high schools offer separate courses.[419] According to the Guttmacher Institute, "an analysis of the characteristics of all schools surveyed, and their communities, revealed that no one type of school or community is significantly more likely than any other to offer sexuality education."[420]

According to Douglas Kirby[421] the reasons for offering sexuality education in the schools include: providing accurate information; to prepare and support young people through development, and reduce their anxieties and fears; increase communication; increase self-esteem, enhance interpersonal relationships, reduce unwanted and irresponsible sexual activity; reduce sexual exploitation; improve skills in

handling social and sexual independence, reduce sexually transmitted diseases and unintended pregnancies.

While family life education programs may vary in content and focus, they typically include:[422] the roles and responsibilities of the family; social problems in families; social and personal interaction with parents, peers, the opposite sex, and others; the life course; family formation; body structure, functioning, hygiene, and disease; sexuality, along with other components embodied in sexuality education, growth and development programs.

According to Dr. Marion Howard, of Emory University, in an article, "Postponing Sexual Involvement Among Adolescents", "adolescents is a time of biological and social growth and development. The varied tasks of adolescence include coming to grips with bodily changes, deciding what it means to be a man or woman in our society, developing a system of values, including sexual values, and developing the capacity for intimacy (both emotional and physical) beyond the immediate family. Adolescence also is a time for experimentation and risk-taking which can foster growth and independence."

In Sexuality Education: A Guide to Developing and Implementing Programs, by Douglas Kirby and others[423] the authors state that, before implementing sexuality education programs, the interactions between age, physical maturity, emotional maturity, and behavior of teenagers should be examined. These interactions range on a continuum from early through middle to late adolescence.[424]

Early Adolescent: Female approximately 10-13, male approximately 11-14.

* Is starting to move to peers but is still quite trusting and respectful of adults.
* Vacillates between clinging and rebellion.
* May be confused, preoccupied with body, wonders "Am I normal?"
* Is just beginning to think abstractly.

Middle Adolescent: Female, approximately 13 to 16; male, 14-17.

* Continues effort to establish separate identity from parents.
* Is strongly influenced by peer opinion.
* May be less trusting and respectful of adults.
* Strives for independence.
* Often becomes idealistic and altruistic.
* Is interested in dating.
* Is experimenting with new ways to behave socially; is trying to establish own values.
* May experiment with sexual behavior.
* Loves intensely, "desperately".
* Continues to develop abstract thinking.

Late Adolescent: Female approximately age 16 and older; male, 17 and older.

* Has achieved at least some independence from parents.
* Has established a more stable body image.
* Begins to love more realistically, with commitment and giving.
* Is more selective in choosing friends, less concerned about the peer group.
* Has developed a relatively consistent framework of values,

* morals, ethics.
* Is able to think abstractly.
* Is attempting to define life goals, especially for careers and permanent relationships.

According to the Children's Defense Fund[425] "we need to put a short of pregnancy prevention "triage" in place. For teens for whom the basic supports are there, such as education, occupational goals, and family experiences and expectations, we need to offer earlier and more comprehensive sex education and better access to contraceptive counseling. For teens for whom basic supports are weak, we need to offer these sexually-specific components while simultaneously strengthening their skills, broadening their experiences, and increasing their opportunities."

The National Research Council states, "While knowledge alone cannot be expected to alter adolescent behavior, education programs that are combined with other approaches, such as assertiveness and decision-making training and role modeling, may help reinforce family values, responsible behavior, and self-control with regard to sexual activity."[426]

In a poll conducted for Time, Inc., by Yankelovich, Clancy, and Schulman, in November, 1986, instruction was favored by 86% of Americans polled; 89% were in favor of children age 12 and up receiving birth control information; three-fourths stated that homosexuality and abortion information should be included in the curriculum; 69% of the parents believed that they did not do enough with their children about sexuality education.

Massachusetts

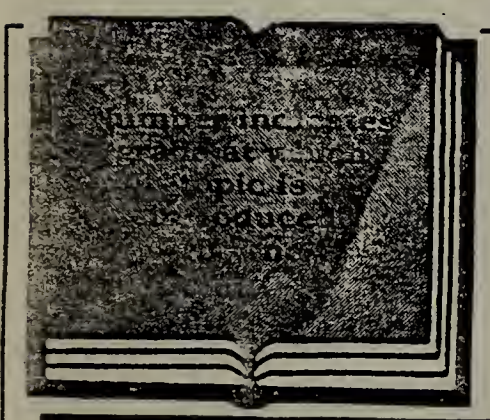
Throughout the Massachusetts Directory of Programs and Services, agencies and service providers who provide outreach and education on sexuality and related issues, indicated these services on their survey. Such services are stated in the services sections by agency in each Health Service Area.

Programs in Massachusetts range from minimal education on sexuality issues, to no sexuality education at all. Some school systems provide or offer short-term seminars, or 4-6 week courses. Some incorporate this subject matter into other coursework; others offer curriculum programs that are sexuality-specific, either on their own, or as an extension of other subject matters. Some programs are offered only in high schools, others begin in elementary schools. Some schools have been offering health education, sexuality education, and family life education programs for many years; others are beginning to implement such programs. Many school systems are expanding on existing programs, others are implementing comprehensive programs.

There are few guidelines for those communities who do offer sex education, therefore there is wide disparity from community to community. The Department of Education, through Chapter 71, mandates that health education curriculums be established in schools, which may or may not include sex education. Often the establishing of these programs evolves around issues of local funding of the programs, and how much money is available for these programs. The establishment of successful programs requires community consensus, and studies have revealed that whenever there is parental involvement with program planning, sex education programs are strengthened, and more topics are covered.

PROGRAMS AND SERVICES: FAMILY LIFE AND SEXUALITY EDUCATION

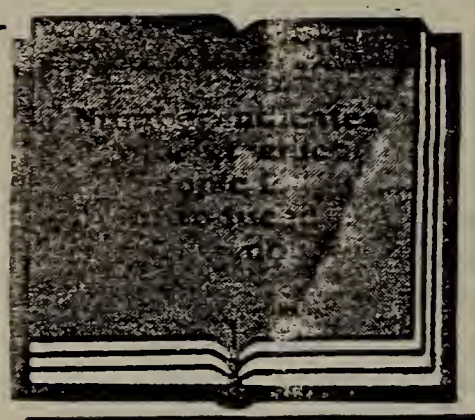
In September, 1986, the Boston Globe conducted a survey of school systems surrounding Route 128. Sources of information included administrators, teachers, guidance counselors and school nurses. The survey is titled, "Sex Education: What Schools Offer, and When". The survey is broken down by city and town, and by subject matter, and by what grade level the subject matter is offered, or not offered at all. The following chart is taken from the Boston Globe.



	Arlington	Belmont	Beverly	BOSTON	Brookline	Cambridge	Chelsea	Dedham	Everett	Gloucester	Lexington	Lynn	Malden	Manchester	Marblehead	Medford	Melrose
Adolescent development menstruation, puberty	6	9	5	10	5	9	5	9	7	5	6	N	10	8	5	N	5
Biology of reproduction-eggs, sperm	N	9	6	8	5	9	7	9	9	8	6	N	10	10	5	10	5
Sexual intercourse	N	N	6	10	5	9	N	10	N	8	8	N	N	10	8	N	8
Venereal disease	N	9	6	10	5	9	N	10	9	8	8	N	10	10	8	N	8
Birth Control	N	N	6	10	8	9	N	10	N	8	8	N	N	10	9	N	9
Abortion	N	N	9	10	8	9	N	10	N	8	N	N	N	10	11	N	9
Sex abuse, rape, incest	N	9	3	10	8	9	N	10	4	8	8	N	N	10	8	N	9
AIDS	N	9	6	10	8	9	N	10	N	8	8	N	N	10	8	N	9
Homosexuality	N	N	6	10	8	9	N	10	N	8	N	N	N	10	8	N	N
Sexual decision making	N	9	6	10	8	9	N	10	N	8	8	N	N	10	8	N	8

Sex education: what schools offer, and when

PROGRAMS AND SERVICES: FAMILY LIFE AND SEXUALITY EDUCATION



	Milton	Nahant	Newton	Peabody	Quincy	Revere	Salem	Saugus	Somerville	Stoneham	Swampscott	Wakefield	Watertown	Waltham	Winchester	Winthrop	Woburn
Adolescent development menstruation, puberty	6	N	5	5	5	N	N	5	5	5	6	9	6	N	5	6	5
Biology of reproduction-eggs, sperm	N	6	5	5	N	N	N	7	7	5	4	9	9	N	5	8	10
Sexual intercourse	N	N	5	7	N	N	N	11	7	5	6	N	N	N	N	N	N
Venereal disease	N	N	7	10	N	N	N	9	7	10	6	N	9	N	9	8	11
Birth Control	N	7	10	10	N	N	N	11	7	N	7	N	N	N	N	N	N
Abortion	N	7	10	10	N	N	N	11	7	N	7	N	N	N	N	N	N
Sex abuse, rape, incest	N	N	10	10	N	N	N	11	7	5	K	N	5	N	N	N	N
AIDS	N	7	10	10	N	N	N	11	9	N	7	N	9	N	N	8	11
Homosexuality	N	7	10	10	N	N	N	11	9	N	7	N	N	N	N	N	N
Sexual decision making	N	7	10	10	N	N	N	11	7	5	7	N	N	N	5	8	N

Sources were asked only to give information on required courses.

In March, 1987, the South Shore Vocational Technical High School Board gave approval for three sex education seminars for students. The students can choose two of the three seminars offered. Professionals from Health Care of Southeastern Massachusetts, Abington, will conduct 45 minute morning sessions. Each of the three sessions will have a separate topic: contraception, sexually transmitted diseases, and options in dealing with sex. The vocational school has an enrollment of about 525 students, from eight member towns: Abington, Cohasset, Hanover, Hanson, Norwell, Rockland, Scituate and Whitman.

In a research paper by Jill McLean Taylor, a doctoral candidate at Harvard Graduate School of Education, "School-Age Pregnancy: The School's Role in Primary Prevention and Seven Mass. Schools," the author states that "in the state of Massachusetts, school sex education is the responsibility of the 351 local school systems." The author refers to a source at the Department of Education, Cheryl Haug-Simons, who stated, "comprehensive sex education programs are very rare, and that schools have a great deal of autonomy in deciding where in the curriculum to place sex education."

The author reviews sex education programs in seven schools in the state. The seven schools and a brief summary of each program are:

Grover Cleveland Middle School:Basic sex education; one-day program for 8th graders, where health providers from outside the school have taught sex education that has covered anatomy and physiology,

reproduction, and some decision-making. The program was initiated during the 1984-1985 academic year.

English High School: Program has a health education curriculum which is the responsibility of the physical education department. The course expands on basic anatomy, physiology, and reproduction, into relationships. The course runs for one semester, and does not have an evaluation component.

Needham and Wellesley: Needham has a strong health education curriculum in the expanded sex education category in the 5th grade for the last 12 years, and is taught by the health education department. Wellesley has basic sex education that is a short unit - five week, once a week- in the 5th grade, covering anatomy and physiology in segregated groups, and no official sex education in the high school or junior high school. Topics are covered in 8th grade science that include human anatomy, 10 grade biology, which covers basic reproduction, and a home economics class, which offers a course in human development. The Needham program developed and piloted a 5th grade program in 1970, with an 80% participation rate, which has increased to 99%. The class is a 15 week unit meeting one period a week for 50 minutes. Parental permission is required and parents are invited to a two hour evening presentation before the program begins.

Cambridge School System: Cambridge has an extended sex education program in the elementary schools, an Adolescent Parenting Program in the high school, but no official sex education in the high school. Sex education courses taught by Cambridge Family Planning Services are now part of the curriculum in the 5th or 6th grades and the 7th or 8th grades. They were first offered in 1976 as an after-school program, and gradually some of the 11 elementary schools requested the course in school hours. Parental permission is required.

Cambridge Rindge and Latin: School has an Adolescent Parenting Program (see Directory), which has been in place under the auspices of the Home Economics Department since 1981. An actual sex education course is not offered, although a year long health education course which includes sexuality education and birth control is part of the 10th grade curriculum. The school nurses' office offers family planning services only to those adolescents who have become parents.

Holyoke: In the elementary schools, a new program of sex education began in the 1985-1986 academic year. The curriculum is the Seattle II, "Here's Looking at You", which was designed for the prevention of drug abuse, but is adaptable for use with human sexuality. The curriculum is being used for K-3 and 4-6 grades. In the junior and senior high schools a part time health educator covers drugs, alcohol, smoking, and "sexuality to some extent" in a 3 times per week, 10 week segment. The 8th graders have 4 different sessions on sexuality, and the issue of birth control is discussed. Parental permission is sought.

Milton Academy: The school has a comprehensive sex education/ human sexuality program plus a comprehensive school-based health clinic on-site. The program begins in the 5th grade with a 7 week course taught by a health educator and a school nurse. In the 9th grade, a required year-long course in health education includes a unit on human sexuality. The class meets once week for a 50 minute period. In the 10th, 11th, and 12th grades, a voluntary 8-week course,

"Human Sexuality and Relationships" is offered. Groups of 10-12 students meet once a week for 1-1/2 hours in the evening at a faculty members home.

Many parochial schools in Massachusetts offer courses in human sexuality, and cover a range of topics, including birth control, human anatomy and physiology, AIDS, self-esteem, and decisionmaking and sexual responsibility, among other topics. Some school systems contract with agencies; many contract with St. Margaret's Hospital Family Life Education Center, in Dorchester, to come to the school and offer curriculum programs, seminars, and educational series on all aspects of family life education.

Legislative Initiatives

Comprehensive Education Programs established through a discretionary grant program from the Mass. Dept. of Education, are previously discussed in this section.

In 1987, State Representative Patricia G. Fiero, filed legislation to Establish Family Life Education Programs in the Public Schools of the Commonwealth. In 1988, the legislation was filed, with revisions. House 2057, "An Act to Encourage Family Life Education Programs in the Public Schools of the Commonwealth" outlines certain premises upon which programs could be developed for implementation in the public schools. Programs would be established in grades PK-12, and would be appropriate to each grade level, and the age and level of maturity of the students. Parental and community involvement are strongly encouraged in the developing and implementing of these programs. Curriculum subjects would include: the physiology, psychology, economic and social aspects of family life; communication and problem-solving; human sexuality, anatomy, reproductive health; interpersonal relationships; living skills and life management; practical and social skills; pregnancy, childbearing; child development; family life; information concerning a broad range of protective behavior; health issues of today, among other topics.

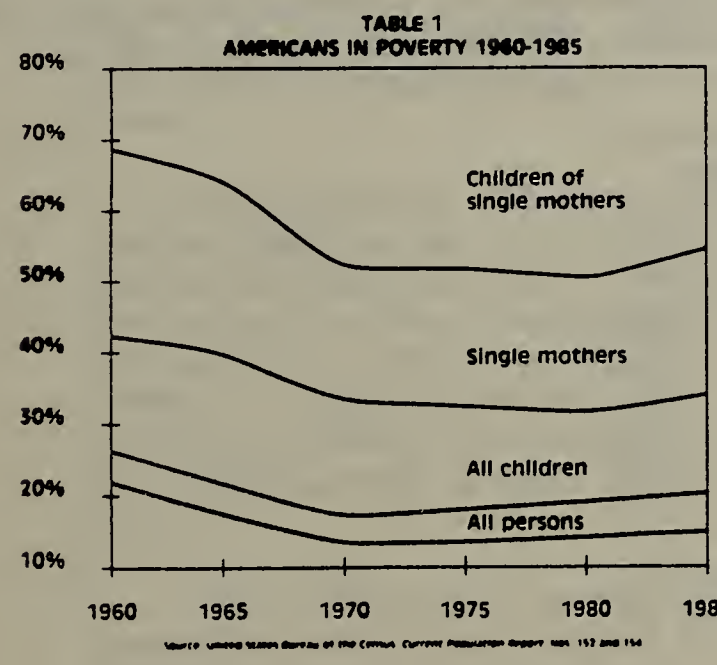
The Department of Education would select a standardized curriculum, and would select age- and grade-level appropriate questions from the curriculum and test students on a statewide basis, in order to determine levels of students' ability to master appropriate subject matter.

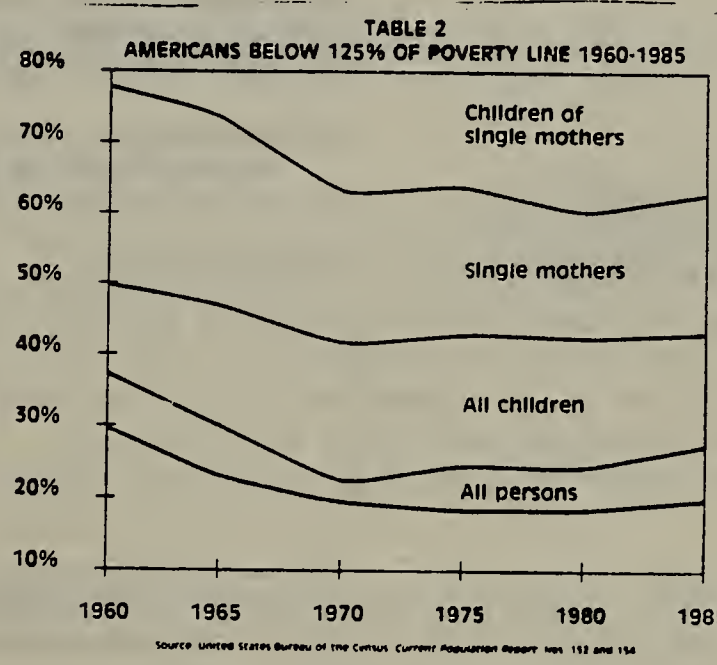
AIDS CURRICULUM

The Massachusetts Departments of Public Health and Education have developed a curriculum to be used in the public schools. The curriculum is titled, "Learn and Live: A Teaching Guide on AIDS Prevention". Topics covered include: "Myths and Facts", "Understanding the Basic Facts About AIDS", "How Can AIDS be Prevented?" and other similar subjects.

Poverty

From 1975 to 1985, the poverty population grew by 28%. Among the poor are unprecedented concentrations of women and children. Children are the most vulnerable members of our socity...they are also our future strength. Yet, 13 million of these children live in poverty. While poverty in the cities is severe, the U.S. poverty rate in non-Metropolitan areas is 50% higher than in Metropolitan areas. One out of five children and youth under 18 years live in families with poverty level incomes - $10,989 for a family of four - making them the poorest age group in the country.[427] The following two charts give data on American in Poverty, 1960-1985, and American Below 125% of Poverty Line, 1960-1985.





Source: State Government News, Women and Children: America's New Poor, 1.87 (Graph Enlarged)

Over 8 million, or 16% of all white children are poor; 4 million, or 44% of all black children are poor. While there was a slight decline in poverty among black and white children between 1984 and 1985, the numbers and rates of poor Hispanic children is rising.[428] In 1985, 2.6 million Hispanic children, or 40.3% were poor, up from 2.1 million in 1982, and 1.5 million in 1979[429] "At the rate of improvement that took place in 1983 and 1984, and assuming there are no recessions, it will take 30 years, nearly two generations, to lower the numbers of poor children to the already high levels of 1979. If trends continue, by 1990, one out of five white babies and 3 out of 4 black babies are destined to poverty." 430

In 1984, 5.5 million young people, ages 14-21, or 18% of all youth in this age group, lived in families below the poverty level. These numbers are greater for minority young people.[431] Among many of these youth, "dropout rates, unemployment rates and other problems found among disadvantaged youth are inextricably related to, and stem from, a common problem - poverty."

PROGRAMS AND SERVICES: PUBLIC ASSISTANCE

Poverty

Those persons who live at or just above the poverty line are living in poverty conditions frequently as devastating as those living under it.[432] The term needy is "used to refer to people living at the margins of poverty, or those people and families with incomes at or below 125% of the poverty line."[433]

The following chart gives the 1987 Poverty Income Guidelines by size of the family unit.

1987 Poverty Income Guidelines

These are the federal poverty guidelines released by the Department of Health and Human Services most often used to determine eligibility for federal programs that assist the poor.

All States (except Alaska and Hawaii) and the District Of Columbia:

Size of Family Unit	Poverty Guideline
1	$5,500
2	7,400
3	9,300
4	11,200
5	13,100
6	15,000

For family units with more than six members, add $1,900 for each additional member.

Source: Children's Defense Fund, CDF Reports, Vol. 8, No. 11 April, 1987.

A study for the National Center for Health Statistics in 1985, on the health characteristics of persons according to family and personal income states that "the percent of persons limited in activity because of chronic health conditions increases as family and personal incomes decrease: 29.3% of persons in families with incomes less than $5,000 a year were limited; 8.7% of those those in families with annual incomes of $25,000 or more were limited." Persons in families with incomes of less than $5,000 a year were 4 times as likely to be assessed in fair or poor health as were persons in families with annual incomes of $25,000 or more, according to the study.

Families, Single Parent Families, and Children in Poverty

According to the Children's Defense Fund, the poverty rate among all families with heads under age 25, including 2-parents, is 29.4%, 3 times the national average. Increasingly, poor families need substantial help and support in just barely meeting their basic needs. Poverty rates among young white families more than doubled from 12% in 1973 to 25% in 1985. Poverty rates among young black families were higher to begin with but still increased by nearly half, from 43% in 1973 to 62% in 1985.[434]

PROGRAMS AND SERVICES: PUBLIC ASSISTANCE

Poverty

Kay Johnson, of the Children's Defense Fund, in a speech stated, "In 1984, 28% of two-parent Hispanic families with children were living in poverty. In the same year, 24% of two-parent black families with children were living in poverty. The poverty rates for minority families were almost 3 times as high as for white families."[435]

Poverty often strikes women and children the hardest. In 1985, one in seven Americans lived in poverty. At the same time, the poverty rate was 1 in 5 for children, 1 in 3 for single mothers, and 1 in 2 for the children of single mothers.[436]

The poverty rate among all female-headed families is 34.5%.[437] In 1983, the poverty rates were 85.2% for young black female-headed families, and 72.1% for young white female-headed families. Black families are more likely to stay poor.

Approximately 60% of all poor families are headed by women.[438] Young single-parent families are five times more likely to be poor than other families. Only one black single mother in four will escape poverty; one in two white single mothers will escape poverty.[439] Nearly 75% of single mothers under the age of 25 years live below the poverty level.[440] Of all families with children ages 5 years or younger, headed by mothers who gave birth as teens, 67% live below the officially designated poverty level. Among mothers under age 30 tears who have not finished high school, as most teenage mothers do not, the poverty rate is 90%.[441]

From 1960 to the present, the proportion of children living in female-headed households more than doubled for black and white children.[442] Approximately two thirds of all blacks and Hispanics under 18 are living in female-headed households.[443] According to the U.S. Census Bureau, one-half of all children born today will spend at least one year living with only one parent. Nine out of ten will live with their mother.

In 1984, according to the U.S. Bureau of Census, among children in single-parent families in which the mother worked, the median family income was $12,800, significantly less than half the median income of all married-couple families. This amount was higher for families of white children than for blacks and Hispanics. In 1984, the median income of single-parent families in which the mother did not work, was $5,880.

According to Kay Johnson, "While many middle class women have newly become poor as a result of divorce and unemployment or under-employment, a large portion of the new poor are two-parent families who have not become part of the economic recovery."

Poverty

The Children's Defense Fund, in "The Declining Earnings of Young Men" [444] states, "Nearly one-half (48%) of all children living in young families in 1985 were poor - nearly double the 26% rate in 1973. The incidence of poverty among children in young white families nearly doubled during this period, and the poverty rate of children in young two-parent families (whether white or black) more than doubled." Black children of young female headed households are the poorest in the country.

Child poverty is directly related to family poverty. By 1983, there were 5.4 million children living with one parent unemployed and another 5 million children with no parent in the labor force. The Children's Defense Fund [445] states, "By 1984, over 50% of all black children and 14% of all white children lived in female-headed families. 71% of Hispanic children, 66% of non-Hispanic black children, and 40% of non-Hispanic white children living in female-headed families were poor." Being born into a white family headed by a never-married female increases the expected number of years of child poverty by nearly 700%. Black children are at increased risk of long-term poverty regardless of household status.

Children living in female-headed households are 4 times more likely to be poor than children in two-parent families. One out of every 5 children under age 5 years lives below 150% of the poverty line.

Economic Conditions and Job Status

During the middle 1970's, after progress had been made on the "war on poverty", the progress was halted, and poverty rates began an upward climb. The increase occurred at the same time there was an economic shift away from the production of goods toward a greater reliance on the provision of services. "As more workers were slotted into low-paying service industry jobs and the U.S. economy began to stagnate, federal spending for social welfare programs for the poor began to wane. The failure to link program spending to indicators of hardship, such as the unemployment rate, and to adjust benefit levels for inflation, diluted the effectiveness of federal anti-poverty efforts. The weakened government poverty programs coupled with the unfolding transformation of the economy set the stage for a dramatic increase in poverty during the first half of this decade."[446]

The deterioration of the economic conditions of many women and children is closely linked to the types of jobs women hold and the pay they receive. Approximately 80% of all women are still employed in only 20 of the 420 categories of occupations defined by the Department of Labor. Over 20 of these jobs encompass clerical employees, retail sales personnel, light manufacturing and assembly workers, and other types of jobs in the service sector.[447] Wages for these jobs are based on the minimum wage, or are lower than the wages of other occupational classifications. Today the minimum wage is less than 40% of the average national wage.[448] Poverty is caused, in part, by the number of women concentrated in low-paying jobs, and the failure of the minimum wage to keep pace with inflation. Also, in 1986, women earned 64% of those wages received by men.[449]

Poverty

An article in State Government News, "Women and Children: America's New Poor", states, "In 1985, a woman with two children and working full time in a minimum wage job, an income of $6,968, if she worked every week of the year. This amount was below the poverty line of $8,662 for a family of three. A family of four, with both parents working at minimum wage, would have earned $13,936. Both parents would have to work to exceed the $10,989 poverty level for a family of this size.[450]

In 1986, a minimum wage job paid $6,700, only 75% of the poverty level for a family of three. The minimum wage has not increased since 1981, despite a 20% increase in the cost of living since then.[451]

According to the Children's Defense Fund, between 1973 and 1984, the average real (inflation-adjusted) annual earnings among males ages 20-24 fell by nearly 30%. This drop affected the earnings of all young adult males, although young black men suffered the most severe losses - nearly 50%. "The percentage of young black men working year-round has fallen by one-third, from 48% in 1973 to 32% in 1984. Only 12% of black male high school dropouts ages 20-24 had no earnings in 1973. By 1985 nearly half - 43% - of all black male dropouts ages 20-24 failed to obtain any employment."[452]

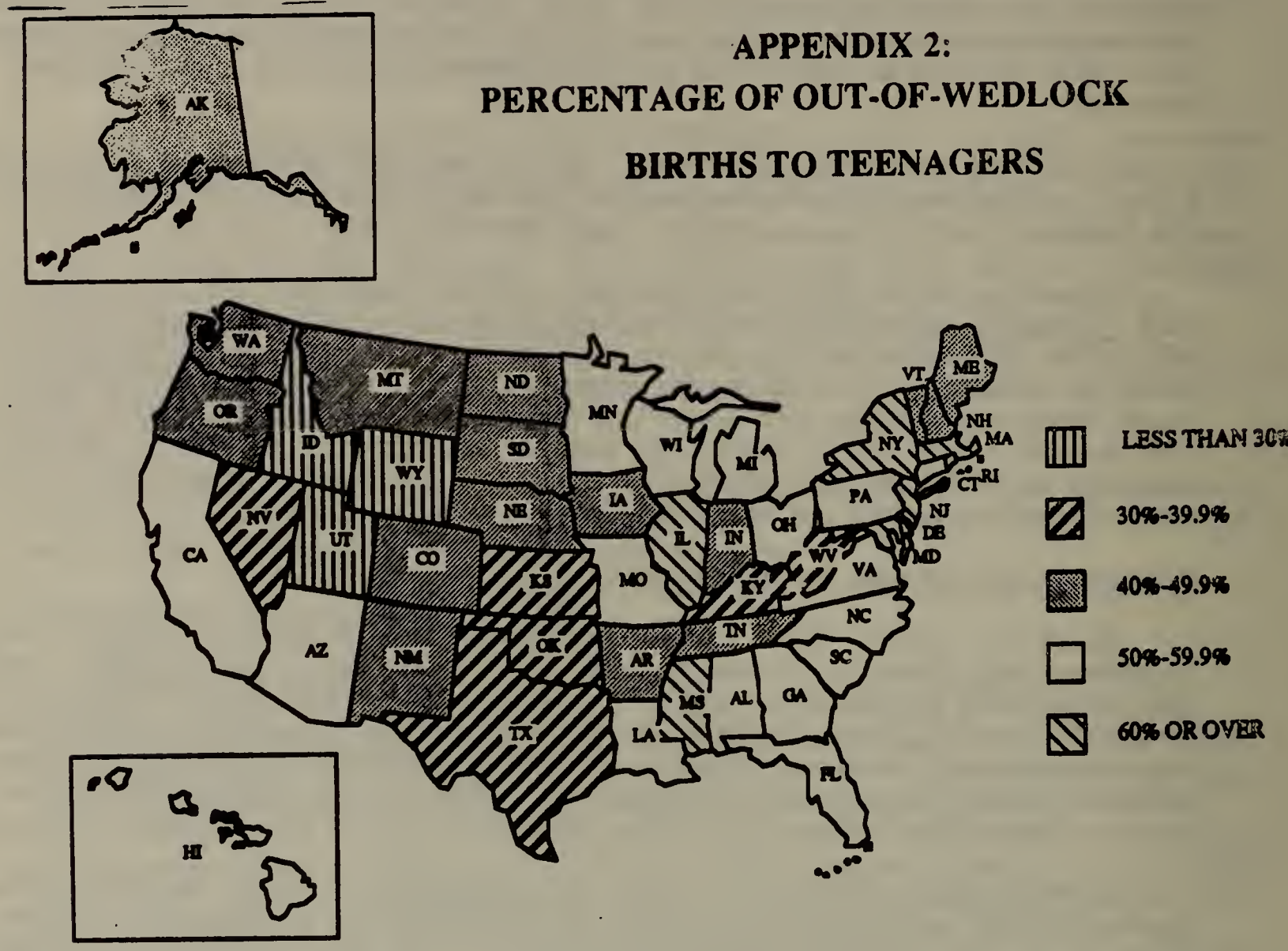
Pregnant and Parenting Teenagers in Poverty

There are various factors that determine a young woman's pathways to welfare dependency and poverty. Births to teen mothers are more likely to mean a potential head of an AFDC household at some point in time for them and their children. Many teen mothers are likely to become part of the poor and near-poor. Because many teenage women are becoming pregnant and having children long before they are prepared socially, emotionally, and economically, teen pregnancy and parenthood are associated with a full range of adverse social and economic consequences.

Between 1950 and 1979, the number of children born out of wedlock in the U.S. quadrupled for both black and whites; in 1985, four out of five young women giving birth are unmarried.[453] According to the Children's Defense Fund, "Women who deliver their babies outside of marriage face greater risks than married women in the areas of poverty, the health of their babies, including low birthweight and infant mortality, and other such social and economic problems."[454] Teen mothers are three times more likely to be single parents than women who delay parenthood until they are in their twenties. The following map gives the percentages of out of wedlock births to teenagers for each state.

Poverty

APPENDIX 2:
PERCENTAGE OF OUT-OF-WEDLOCK
BIRTHS TO TEENAGERS



Source: Preventing Teenage Pregnancy: A Public Policy Guide. Susan E. Foster Council of State Policy and Planning Agencies, 1986.

Poverty

"In 1984, 56% of all births to teens and 25% of all births to women ages 20-24 were to unmarried women - a dramatic increase from 1970 when only 30% of teen births and 9% of births to 20-24 year old women were out of wedlock."[455] The following chart gives the disposition of first births to unmarried teenage mothers.

TABLE 2-15 · Disposition of First Births to Unmarried Mothers Ages 15–19 (percentage distribution)

Living Arrangements of Child	All Races			White and Other			Black		
	1982 (N = 133)	1976 (N = 148)	1971 (N = 259)	1982 (N = 50)	1976 (N = 25)	1971 (N = 39)	1982 (N = 83)	1976 (N = 123)	1971 (N = 220)
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
In mother's household	92.6	93.3	85.6	91.1	87.2	72.2	94.7	96.8	92.4
With relatives or friends[a]	2.5	1.0	4.7	1.5	2.9	5.8	4.0	0.0	4.2
Adopted	4.6	2.6	7.6	7.4	7.0	18.4	0.7	0.0	2.0
No longer living	0.3	3.1	2.1	0.0	2.9	3.6	0.6	3.2	1.4

[a]"Friends" was a valid code in the 1971 and 1976 surveys but not in the 1982 survey.

SOURCE: C.A. Bachrach, 1986, "Adoption Plans, Adopted Children, and Adoptive Mothers," *Journal of Marriage and the Family* 48: 243–253, May. Reprinted by permission.

Source: Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing, National Research Council, 1987

Youths ages 18-23 who have the weakest reading and math skills are eight times more likely to have children out of wedlock.[456]

In 1982, births to unwed teens under 20 years, in Massachusetts, was 62.3%, ranking Massachusetts the sixth highest in the country in births to unwed teen mothers. In 1984, births to unwed teens was nearly 68%. In 1985, this increased again to over 70%.

The problems relating to family structure also contribute to the generally low socioeconomic status of teen parents and of unmarried women who became parents while in their teens. Only 10% of teens marry while they are pregnant, or during their child's early years. Of those who do marry, the divorce rate is nearly 50%.

According to the Children's Defense Fund, nearly one-half of married women who give birth prior to age 18 are separated and divorced within 15 years, which is a rate three times higher than that of women who first bear children later than age 20. Nearly one-fourth of the separations are within 5 years. By the time these women are divorced or separated, they are likely to have more children, yet are less likely to receive child support payments.

Poverty

Another factor influencing social and economic outcomes for teen parents is subsequent births. An article in the American Journal of Public Health, "Early Subsequent Pregnancy Among Economically Disadvantaged Teenage Mothers", states the results of a study conducted over a 2 year period on 675 young mothers living in 8 U.S. cities. "Within two years of the initial interview, when one-half the sample was still pregnant with the index pregnancy, nearly half the sample experienced a second or higher order pregnancy."[457] Other findings of the study are:[458]

* an early repeat pregnancy was associated with a number of negative short term consequences in the areas of education, employment, and welfare dependency

* the negative consequences associated with teen pregnancy are magnified by occurrence of an early repeat birth

* about 1 out of 5 teen mothers, regardless of race or ethnicity, become pregnant again within 12 months of delivering the first child

* the study refers to a survey done by the National Survey of Family Growth stating that the rate of repeat pregnancy within 12 months of an earlier birth was nearly twice as high among women with incomes less than 150% of poverty than among women with higher incomes

* at an average age of just over 18, teens in the sample had already had more than half of the total number of children they said they wanted to have

* teens with a subsequent birth were less likely to be working or to have a positive school status, and more likely to be receiving AFDC than those teens who avoided another pregnancy

According to CDF, low income teens are at-risk children whose families and communities and schools do not have the means to provide the incentives to delay parenthood and help them on the path to self-sufficiency. These youth need help in the assessment of their skills and interests, an evaluation of their opportunities, and substantial help in getting the services and supports they need to help them deal with the stresses and conflicts present daily in their lives.

Aid to Families with Dependent Children (AFDC)

AFDC is an entitlement public assistance program created by the Social Security Act of 1935, originally to provide federal support for children who did not have fathers living in the home. AFDC provides cash assistance to economically needy individuals who are categorically eligible.

States are given flexibility in determining eligibility and in setting AFDC benefit levels. State programs may vary considerably, from 40% to 96% of the poverty level, which often reflects the range of perceptions about welfare.[459] Each state sets its own need and payment standards. The need standard is the amount a state considers to be necessary to support a family at a minimum living standard in that state. The payment standard is the maximum benefit paid to a family with no other income. Payment standard vary from 33% to 100% of the states need standard.[460] About 26 states do not provide assistance to intact families, choosing to provide benefits only to children of unwed mothers, or to poor families broken by separation, divorce or desertion.[461] AFDC costs can be controlled by changing the levels of these standards of eligibility criteria, or by influencing the flow of recipients onto or off of the welfare rolls.[462]

According to the U.S. Department of Health and Human Services, 10.8 million people were recipients of AFDC during Fiscal Year 1986, 72% of whom were children, and the remaining 28% were heads of households - 90% of whom were women.

In 1986, 30% of children under age 16, and 23% of 16-24 year olds, received welfare. Approximately 60% of the population below poverty level receive welfare, and women account for 56% of the welfare population. About one-half of all those receiving welfare are under age 25 years.[463]

Approximately 48 million Americans, or 19% of the population, receive welfare benefits of some form, including, but not limited to AFDC.[464]

The following chart gives the numbers of AFDC recipients for 1983, by number of families, children and mothers, by race and age.

AFDC recipients, 1983

No. of families	3.6 million
Black*	43%
White non-Hispanic	41
Hispanic	13
No. of AFDC children	7.0 million
Under age 6	42%
6 to 11 years	32
12 to 18 years	26
No. of AFDC "mothers"**	3.2 million
19 to 29 years	73%
30 and over	27

*Race/ethnicity of family head; excludes "other"
**Or other relative or guardian; excludes .4 million "fathers"

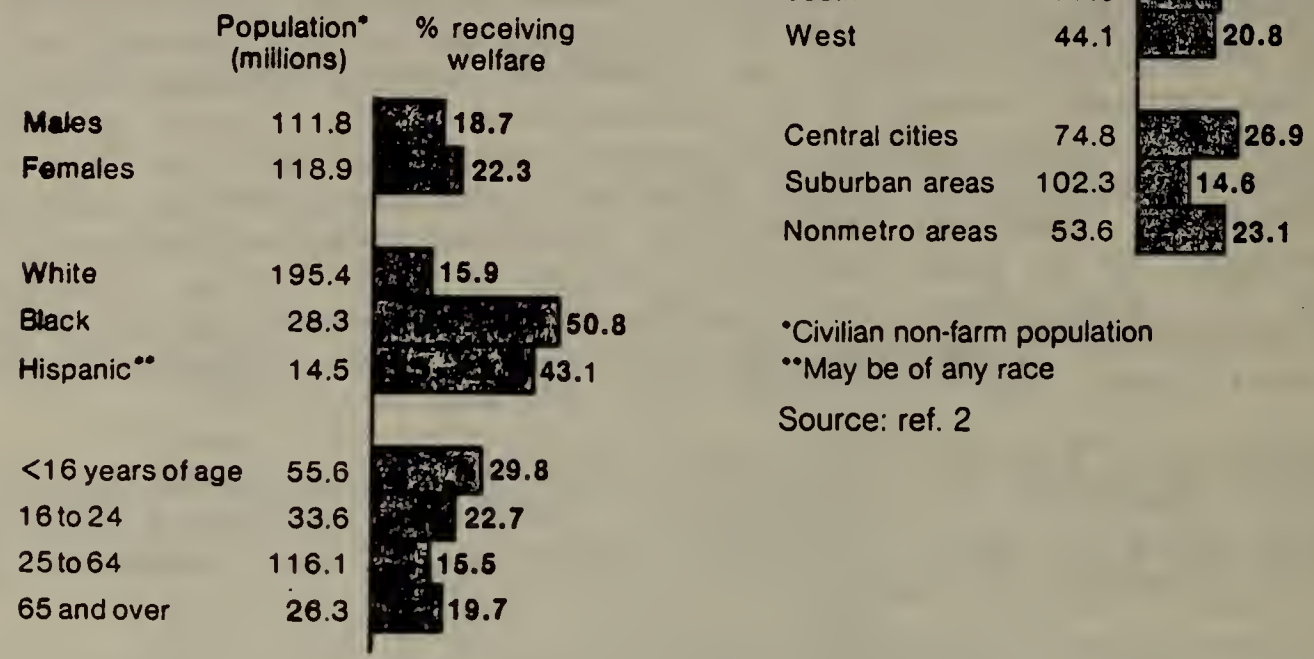
Source: ref. 3

Source: America's Welfare Population: Who Gets What? O'Hare, W. Population Reference Bureau, Inc. No. 13, Sept. 1987.

Source: America's Welfare Population: Who Gets What? W. O'Hare, Population Reference Bureau, Inc., No. 13, Sept., 1987 (Both Charts)

The following chart gives the percentage of Americans receiving one or more welfare programs, by male/female, race, age, area of the country, cities, suburban areas and nonmetro areas, for the first quarter of 1986.

Percentage of Americans receiving one or more "means-tested" welfare benefits, first quarter, 1986



*Civilian non-farm population
**May be of any race

Source: ref. 2

Between 1970 and 1979, about 15% of AFDC recipients spent 8-10 years on welfare. In 1983, 61% of AFDC recipients surveyed had received AFDC for less than 3 years, but almost a quarter had received welfare for 5 years. For some families, leaving welfare may occur at some point in time, but often these same families return as recipients at a later time.

For most AFDC families in the country, 93% have lost the support of one or more parents due to continued absence of the parent from the home. Movement into or out of welfare systems are usually tied to a change in family or living status.

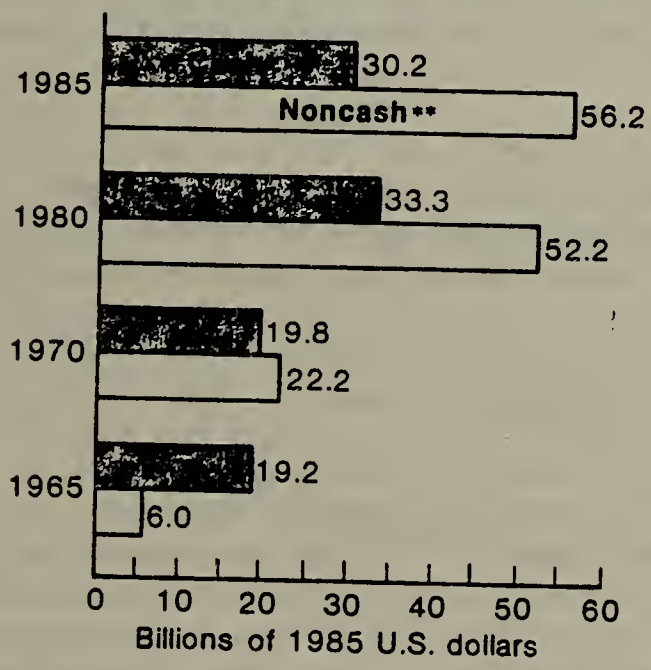
Costs

According to the Department of Health and Human Services, the cost of welfare dropped for the fifth straight month, between April, 1987, and August, 1987. Caseload numbers decreased and the number of households receiving AFDC declined by 313,000 to 10.89 million. The average AFDC payment per family was $366.12. Reasons attributed to this were increased child support enforcement, and more people obtaining jobs. Other reasons could be posed for the decline, as well as other influencing factors, but these are not given by the Department. In January, 1987, the average AFDC cash grant for a single parent family with two children was $354 per month, but cash

assistance may not be the only benefits received by a family.[465] It is difficult to calculate the total value of benefits received by a typical needy person since benefits vary state by state, and much of the Federal aid received is noncash assistance, such as public housing and medical care. The total amount of expenditures for welfare rose rapidly until 1980, with a slight upturn in the early 1980's, due to a dramatic increase in health care costs, causing a 15% increase in Medicaid outlays.[466] The primary type of welfare benefits has shifted from cash to noncash assistance. The distinction between cash and noncash assistance is important because only cash benefits are counted as income in poverty statistics.

The following charts give the expenditures on major Federal and State welfare programs, for twenty years, 1965-1985, on cash and noncash assistance levels, and annual expenditures per recipient by federal, state and local governments, for four major welfare programs, 1965-1985.

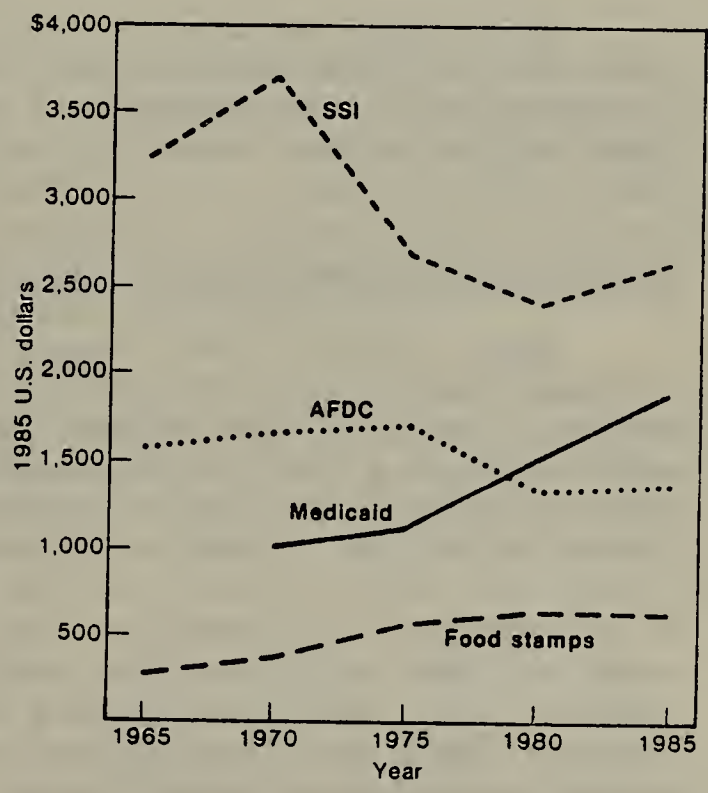
Expenditures on major federal and state welfare programs, 1965-1985



*AFDC, General Assistance, SSI, and Means-Tested Veterans pensions
**Food Stamps, Medicaid, Public Housing, and School Lunches

Source: ref. 4

Annual expenditures per recipient by federal, state, and local governments, four major welfare programs, 1965-1985 (in 1985 U.S. dollars)



Source: ref. 5

Source: America's Welfare Population: Who Gets What? W. O'Hare, Population Reference Bureau, Inc. No. 13, Sept. 1987 (both charts)

AFDC

Welfare and Poverty

In 1985, the Government spent at least $130 billion on welfare, but still had 33 million people in poverty.[467] One of the reasons the poverty gap persits may be attributed to the fact that noncash welfare expenditures are not reflected in official poverty statistics because they are not counted as income. "However, even when noncash benefits were added, the numner of Americans below the poverty level remain between 22 and 30 million. Most government programs are designed to provide minimum assistance for the needy, not to raise incomes enough to move families out of poverty.[468] An example of this would be: The median value of monthly cash welfare payments plus food stamps for a family of three in January, 1986 was $524, equaling an annual income of $6,288. The government's official 1986 poverty level for this type of family was 39% higher than this amount, at $8,737. According to the Population Reference Bureau, "The poverty index is seldom used for eligibility. Many programs provide benefits to people with incomes above the poverty line. Some welfare benefits, particularly Medicaid, go to people in nursing homes and other group living persons, or to the homeless, who are not counted in poverty statistics.[469]

In recent years, the poverty gap has been around $50 billion, that is, if $50 billion was spent on public assistance, added to the amount already spent on cash welfare and distributed with perfect efficiency, no American would have an income below the poverty line.

Factors Associated with Entry into Welfare

Many factors are associated with welfare status; marital status, race, educational attainment, employment history, age at first birth; and subsequent fertility.[470] On the average, 45% enter because the mother became divorced, separated, or widowed; 30% enter because unwed women gave birth to a child; 16% enter because a family income declined; and 9% enter for other reasons.[471]

Divorce, separation and out of wedlock births account for most of the children who require welfare. States attempt to provide for some two-parent families; about one-half of the states attempt to provide assistance to families with unemployed fathers under restricted conditions. Most families are headed by single females.

Teen Parents and Welfare

More than one-half of all AFDC households are headed by a mother who was a teenager when the first child was born. Nearly 70% of all AFDC households headed by women under 35 years, have mothers who were teenagers when their first child was born. Research studies have shown that despite the fact that teen mothers are disproportionately represented in welfare programs, public assistance is not their preferred means of support.[472]

PROGRAMS AND SERVICES: PUBLIC ASSISTANCE

AFDC

Public assistance is an important source of economic security when husbands or parents and families are unable to meet the necessary level of financial support. "The single largest source of public support for teen mothers and their children is through federally funded and state administered AFDC programs. They provide cash assistance to needy women who are eligible as female heads of households with children under 18, who meet specific eligibility requirements regarding income. Female subheads, that is, teen mothers living in the same household with their mothers or other unrelated primary householder are eligible for themselves and their children, or for their children only. Food stamps recipients and Medicaid health insurance are available to AFDC recipients." [473]

A 1982 study from the Center for Population Options stated that projections of public sector costs associated with adolescent parenting, with continuation of present trends, are that women 20-29 will cumulatively receive $47.5 billion in AFDC, Medicaid and Food Stamps between 1981 and 1990. Of this amount, $39.6 billion will go to women whose first births occurred when they were under 20 years. Nationally, the 387,000 first born infants to teen mothers in 1985 alone could cost more than $6 billion over the next 20 years. In 1985, the cost for a first birth to an unmarried teen was estimated at $13,902.[474]

While not all pregnant and parenting teens become dependent, and many do complete their education and go on to higher education and better paying jobs, for others, one child creates significant obstacles to social and economic opportunities, and several children further lowers the chances for economic independence and self-sufficiency. Some remain on public assistance programs for moderate periods of time; others remain dependent indefinately.

Teen pregnancy is related to the length of time some families may remain on AFDC. According to the article, "Innovative strategies for State Social Services," "Most women who go on welfare receive assistance for relatively short periods. More than half stay for less than two years. However, research suggests that the teenage mothers are likely to be long-term welfare recipients...a high school dropout who had a child as a single parent averages ten years of welfare receipt." [475]

"A birth to a teen living in a family that receives public assistance reduces the probability that the young women will leave welfare to almost zero. There are sizeable numbers of three generational households with whom interventions are needed to break the intergenerational transmission of poverty." All of these factors are amenable to change and improvement and remediation, if appropriate, consistent, and substantial interventions are provided, early and of the duration and quality necessary.

While there is consistent data indicating that many teenagers who become pregnant and give birth experience difficult lifestyles,

and are economically dependent on public assistance for moderate and long-term periods of time, there is a recent study that some become self-sufficient eventually, after their children are older. Frank Furstenburg of the University of Pennsylvania, conducted a study that began at Mt. Sinai Hospital in Baltimore in 1966. The sample consisted of several hundred predominantly black pregnant teenagers in Baltimore, who were followed from their pregnancy in the late 1960's until the mid-1980's, when the mothers were in their thirties.

At the five year follow-up, over 400 mothers were interviewed and studied. At that time, more than one-half of the marriages had dissolved, and among those who were still married, a substantial number reported severe marital problems. Those who had divorced or never married were disinclined to enter or re-enter marriage.

At the seventeen year follow-up, there was a much wider diversity of outcomes. Furstenburg and his associates, J. Brooks-Gunn and S. Philip Morgan, conducted the follow-up study on 322 of the original participants. Some of the findings are:[476]

1. Less than one-fourth had never married; less than 10% had neither married nor entered a co-habitational relationship.

2. The relationships of the women who had married or cohabited were mostly not permanent. Approximately two-thirds had dissolved, as were many second marriages and relationships.

3. Early childbearers were less likely to be married than their peers who delayed childbearing, and were less likely to remain in their first marriage.

4. Among the small proportion of early childbearers who enter stable marriages, economic outcomes are more favorable than those who do not marry and become single heads of households.

5. Infants born to teen mothers who are married at the time of birth have more favorable outcomes than those of unmarried mothers.

6. Women who were early childbearers stated that they had fewer children than they had originally indicated they had wanted, and had fewer children than they had indicated they expected to have at the five year follow up.

7. About 25% were on welfare at follow-up, when in their early 30's.

8. Strategies should be aimed at males as well as females.

9. With few exceptions, single mothers did not earn enough from their own employment to place them in the top economic quartile.

10. 30% of the mothers had received some postsecondary education and 5% had completed college.

AFDC

Teenagers and Eligibility

Despite the disproportionate number of teen mothers receiving AFDC, only a scattering of welfare departments have special programs or services oriented to teen parents.[477] Some have included specific caseworkers to specialize in teen services, to act as liaisons with school personnel, social service workers, Food Stamps and WIC services, Medicaid and day care and group counseling. California requires that welfare workers refer teen parents to school or an educational program; Maryland has developed a state-wide program oriented toward single parents; Illinois has surveyed the status and needs of teen parents on welfare.

If a teenager is unmarried, her baby may be categorically eligible. If the teen is unemployed or only marginally employed, the baby is likely to meet income standards for AFDC. The teen may or may not be eligible, depending on the income and resources of her own parents, since they are responsible for her while she is 18 or younger.

The 1984 Deficit Reduction Act amendments to the Social Security Act established that teen parents eligible for AFDC and living with parents must be included in a household grant. Minor mothers living apart from their families are eligible to receive benefits on their own. This area has caused concern in that this requirement may be an inducement for many teen mothers to leave their families, and possibly stability and support that living at home may provide, and establish independent living arrangements. States should explore possible options to allow adolescent parents under age 18 to remain in their families of origin whenever possible until at least high school completion, or equivalency, or until economic self-sufficiency can be achieved.

"There is no evidence that AFDC benefits encourage young women to become sexually active, or to become pregnant, but there is evidence that requirements may influence decisions concerning living arrangements."[478]

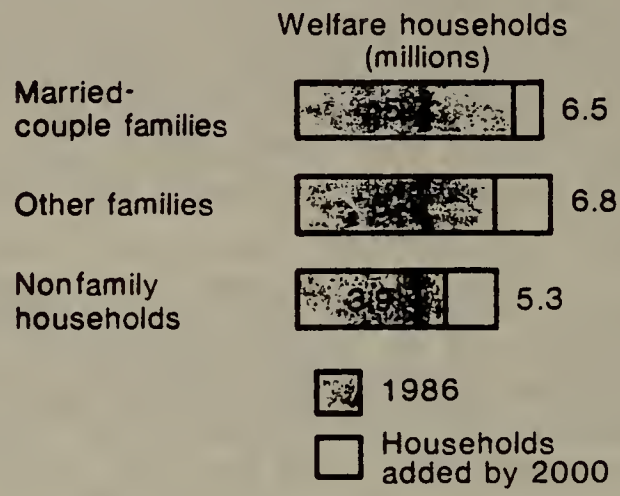
Hofferth[479] states that "Several studies have tested the association between welfare and adolescent fertility, and none has found any impact of either the level of AFDC benefits or acceptance rates on birth rates among unmarried teenagers."

Trends

The U.S. Census Bureau projects that between 1985 and the year 2000, 29 million Americans will be added to the Welfare population. The number of welfare recipients, with no change in the distribution of people and households, in 2000 would be about 53.5 million, up

from 47.5 million in 1986. The following chart gives increases in welfare households between 1986 and 2000.

Increases in welfare households, 1986-2000



Source: ref. 8

Source: America's Welfare Population: Who Gets What? W. O'Hare, Population Reference Bureau, 1987

The characteristics of the welfare population will change, according to the studies from the Population Reference Bureau, due to three main demographic trends:

1. the aging of the U. S. population
2. continued migration from the northeast and midwest into southern and wester states
3. increases in single parent families and nonfamily households

Between 1986 and 2000, those born between 1947 and 1964, so-called "baby boomers" will move into the 35-54 age range, and the average U. S. age will go from 32 to 36. Immigration is another demographic trend, but little is known about the use of welfare by immigrants.

Welfare Reform

Welfare reform has become one of the most volatile and complex issues of the 1980's. The disagreement is basically on who are the people in need of aid, and what is the best approach to helping them. Much research is needed on the characteristics of the welfare population, and what considerations should be given to conditions moving them off welfare, and onto welfare, in order to formulate accurate perceptions, and correct misperceptions. Appropriate interventions can then be expanded and put in place.

Despite expenditures annually of $130 billion or more on public assistance programs, the poverty gap, and poverty itself, persist. Many people who are poor, near-poor, and becoming poor,

fall deeper into poverty and the negative consequences resulting from poverty. [481]

Current welfare policy initiatives focus on more uniform state eligibility rules; extending child care benefits and Medicaid to ease re-entry into labor force and job training. They do not focus on curing poverty, or on the direct root causes of poverty.

There are many views on the current proposals made for welfare reform. Some of the proposed divergent reform measures before Congress are:

1. Extend AFDC to needy children from two parent families, unemployed.
2. Intensify efforts to identify and contact fathers of welfare children.
3. Authorize deductions of child support from parent's paychecks, usually the absent parent.
4. Offer welfare eligibility to unmarried parents under 18 only if they live with their own parents or in state-regulated homes.
5. Boost state benefit payments with the government absorbing most of the increases.

Some criticize the proposals as too costly - an estimated $2.3 to 5.2 billion over a five year period.

Others propose adjusting AFDC benefits to keep up with inflation and setting a national minimum for program benefits. Some propose including the working poor in job training programs to help in eroding the causes of poverty.

Some of the welfare reform proposals are discussed in the section on Federal Funding, such as Senator Moynihan's proposal.

The Children's Defense Fund has outlined current welfare reform views in CDF Reports, "News and Issues:, May, 1986; and has updated information on the various proposals since then. In one article, "A Beginning Look at Welfare Reform", basic reform measures are outlined. CDF states that any proposals should contain elements that are pro-jobs, pro-family, and that welfare reform must establish a national minimum standard of subsistence, and should encourage the transition to self-sufficiency. CDF states that jobs and job training should be provided to disadvantaged Americans, and the minimum wage should be increased to a level that can support a family decently.

.Most public assistance programs have some form of work requirements for recipients, unless they are ill, disabled, or have caretaker responsibilites.

 PROGRAMS AND SERVICES: PUBLIC ASSISTANCE

AFDC

One of the main thrusts of the welfare reform movement has been to expand and enhance job search and job training components, in an effort to reduce long-term welfare dependency.

The types of programs initiated have often been through the incorporation of employment incentives into welfare programs. Among these are:[482]

* WIN projects to educate and train, and find jobs for recipients.
* Workfare programs that require recipients to work on community projects.
* Structured job search efforts, sometimes through a job club.
* Work supplementation which diverts welfare benefits to job training.

The success of many programs, and measures of the effectiveness of outcomes, are inconclusive.

Congress is considering various approaches to encourage welfare to work schemes:

1. pay part of child care and transportation costs of employed recipients

2. allow employed recipients to keep more of their earnings without losing benefits

3. extend Medicaid and child care benefits for several months after a recipient leaves welfare to begin a job

Some new proposals ask that work programs excuse parents only when their children are under 3 years, or they are unable to get child care.

Marian Wright Edelman, in her recent book, Families in Peril, states that a problem inherent in the concept of welfare to work programs is that many people do not have adequate skills to compete in, and complete job training programs. "Sixty percent of all adults on AFDC have not graduated from high school, and at least one in four has no prior work experience. An Educational Testing Service study in 1983 found that among WIN registrants, 3 in 5 had math skills, and nearly half had reading skills, below 8th or 9th grade level." Edelman points out that parents must have adequate child care, and that 61% of AFDC parents in 1983 had children younger than 6 years. Also, "A substantial number of AFDC recipients do have the potential and motivation to move from welfare to work and eventual self-sufficiency. But this can only

AFDC

be done if they are given adequate help and support, medical care, training, transitional child care, basic skills, and health insurance assistance.[483] Edelman cites Massachusetts, Maryland and Maine as having good model programs that are attempting to provide job training and placement, and to remove barriers in the welfare to work transition.

Concerns are expressed in the pamphlet from the Population Reference Bureau about the numbers of persons who would be reached and brought out of poverty through welfare to work programs. "Job training and placement services would reach only a fraction of all poor adults, especially if tied to AFDC. Less than one-fifth of the 20 million adults in poverty participate in the AFDC program. Even if such programs cut the number of AFDC recipients in half, the number of adults in poverty would fall by less than 10%."[484]

Massachusetts

AFDC is a state and federally funded program that provides monthly financial grants to families with children who have no other source of income. The AFDC program is jointly funded -50/50 - by federal and state governments. There is a higher percent for state funding for optional programs. The state government is responsible for establishing eligibility guidelines and grant levels. Checks are paid twice a month. In specific instances, AFDC is available to pregnant women, and is available to needy pregnant women at all stages of their pregnancy. In January, 1985, the Legislature extended eligibility for AFDC to pregnant women in their first or second trimester, who have no other dependents. Federal matching funds for this expansion had previously been eliminated by President Reagan in 1981, as part of the Omnibus Budget Reconciliation Act (OBRA).

In Massachusetts, there are approximately 300,000 AFDC and General Relief (GR) recipients. The Department of Public Welfare reports that "while the Department currently (Oct. 1987) serves about 85,000 cases per month, nearly 120,000 different families use AFDC over the course of a year. Clients often leave the welfare rolls and re-enter some time later." The Department also states that ET (Employment and Training) and improved child support enforcement have played a significant role in moving families out of poverty, representing one-quarter of those leaving the caseload.

Of the 252,000 AFDC recipients in Massachusetts, 168,000 or 66%, are children. Nearly one-half of these children are under age 6 years. The average length of stay on welfare is usually less than two years, but for women who start receiving AFDC as pregnant and parenting teens, the stay is often much longer. Nearly 86% of AFDC families are headed by a single female parent. Approximately 88% have no other source of income. Approximately 63% of AFDC recipients are white; 18% are black; 18% are hispanic and 1% are Asian or native American.

Approximately 63% of families on AFDC in Massachusetts pay 75% of their income for rent. Only one-third of AFDC recipients live in public subsidized housing.

AFDC-Massachusetts

In October, 1987, the Department of Public Welfare issued a report on AFDC Caseload Trends. Among the findings contained in the report are the following:

1. Due to the increase in births to unwed parents and a rising divorce rate, the number of single parent families in Massachusetts has increased by 23% since 1983.

2. The number of births in Massachusetts has increased consistently since 1980. Over 25% of the children born every year use welfare before the end of the following year. From 1980 to 1985 births to unwed mothers increased 33%.

3. The proportion of parents on AFDC who are unwed parents has increased from 37% of the caseload in 1983 to 53% of the caseload in 1987.

4. While 62% of all AFDC clients in 1984 had completed high school, the percentage of all clients now who are high school graduates declined to 48%.

5. In 1983, 42% of all clients had previously used welfare. In 1987, 52% of all current clients have had previous welfare stays.

6. New clients coming onto the caseload are younger, less likely to have work experience, and more likely to have used AFDC previously.

7. The number of families on AFDC for five or more years has decreased from 20,800 to 14,700, a decrease of 29%.

8. The average length of stay on AFDC has declined from an average of 37 months to under 28 months, a decline of 25%.

9. The number of two parent families on AFDC has dropped from 2,836 cases to 1,163, a decline of 59%.

10. While the number of whites and blacks on the AFDC caseload has dropped since 1983, the number of Hispanic families has increased by 32%.

11. Between 1983 and 1987, the age distribution of AFDC clients has remained relatively stable. In both 1983 and 1987, the average age of AFDC parents was 30. The portion of parents on the caseload who are teenagers has stayed at 6-7% of all AFDC cases. Teenage parents are an important group in that they are prone to remaining on AFDC for very long periods. About 50% of all AFDC mothers had their first child when they were a teenager.

AFDC

Pregnant and Parenting Teenagers

According to the Department of Public Welfare, in it's FY87 Budget Narrative, "one of the most dramatic shifts in the composition of the AFDC caseload is the increase in the proportion of AFDC parents who have never been married. In 1975, only a minority of AFDC single parent families had never married (23%). By 1985, half of all AFDC single parent families had never married. AFDC dependency is more and more the product of births to unmarried women and the lack of family formation, rather than the result of marital dissolution."

The number of teens, by age, who gave birth in 1984 and 1985, and who were unwed, is stated as follows:

Age	1984	1985
under 15	81	108
15	244	273
16	620	605
17	1032	1026
18	1376	1412
19	1393	1494

Data Source: Mass. DPH, Div. Health Statistics and Research

According to the Department of Public Welfare, "one of the most unfortunate consequences of the growing proportion of births to unwed parents is the number of Massachusetts children in poverty. Over 19% of all children born in Mass. during 1984 had spent some time on welfare caseloads by November, 1985, and 17% had received AFDC. When a single parent family is headed by a young parent, the incidence of poverty is particularly severe. 29% of all children born in 1984 to a mother under age 19, or 2,035, had been on the AFDC caseload by November, 1985. There is a relationship between teen pregnancy and persistent welfare dependency." Of all AFDC single female parents under 35 years of age, about 50% gave birth to their first child while under 19. This means that 27,200 single parents on AFDC were 19 years or under when they had their first child. About 80% of teen parents are the daughters of teen parents.

In 1985, 12.5% of entrants into the AFDC caseload were under 19 years of age, an increase from the 1984 level of 11.4%. Entrants are becoming younger, making it difficult to involve them in job training and job placement programs. In March, 1985, 5,907 teenage parents were on welfare with their own AFDC caseloads. This includes cases in which the teenager and her dependent are eligible for AFDC and those cases in which only the dependent child is eligible. There are 153 teen parents who are 15 years old and under who are heads of AFDC households. In 1985, there were 802 cases of teens who were pregnant with no other dependents. These figures do not include those pregnant and

parenting teens who live with their own parents and are therefore on their mothers' AFDC grants. Outreach to teens who live with their parents is difficult because they often do not have contact with the local welfare offices and social services agencies.

There are currently approximately 8,000 teen mothers and pregnant teens receiving AFDC in Massachusetts. While the Department of Public Welfare can identify all teen clients and those teen clients who have their own AFDC cases, it cannot identify those teens who are pregnant or are parents and are living at home on their mothers' AFDC grants.

AFDC Eligibility Requirements for Pregnant and Parenting Teenagers

AFDC is available to needy pregnant women at all stages of pregnancy, even if she lives with the father of the child or has children in the home. The amount of AFDC she receives depends on her own income and resources as well as the income and resources of her spouse if married; of her parents, if under 18; of her children who are related to the unborn child, if they have income. While eligibility standards and requirements may be complicated in some cases, pregnant and parenting teens should apply to the Department of Public Welfare for a review of their cases, and should become informed of all benefits, and their rights regarding these benefits.

The sources of the following information are the Massachusetts Department of Public Welfare, Mass. Law Reform Institute, the Coalition for Basic Human Needs, the Alliance for Young Families, and other groups.

1. A pregnant woman, 18 years or older, can receive a maximum grant of $333, or $373 with rent supplement, if she has no other income, whether or not she lives with her parents. This monthly amount is reduced by any other available income, as well as any free rent, utilities, or food provided to her.

2. A maximum grant of $333, or $373 with rent supplement is available to a pregnant teenager with no other income who does not live with her parents.

3. If she lives with her parents, a pregnant teenager under 18, is eligible for AFDC as a dependent child only if her parents are also AFDC eligible (meeting both financial and categorical requirements). Her benefits will be included in her parent's grant.

4. If her parents are over-income for AFDC, a pregnant teen under 18 may still be eligible for AFDC as a pregnant woman, depending on the amount of parental income. The parent's income is measured against the AFDC need standard for the family size. The difference above the AFDC need standard amount is considered available income to the pregnant or parenting teen.

5. A teen mother under 18 years of age who lives with her parents who are financially ineligible for AFDC, is only eligible for AFDC for her baby, depending on the amount of parental income. Grandparents income is "deemed" to a baby in the AFDC program. General Relief and Medicaid benefits are available to the baby if AFDC

5. is denied due to "grandparent deeming". The GR and MA programs do not have these "deeming" rules.

6. If her parents are receiving AFDC for themselves and other siblings, a parenting teen must receive AFDC for herself and her child on her parents' grant. She does not have the option of a separate grant.

7. If the parenting teen is the only dependent child in the home under 18, she may prefer to remain on an AFDC grant with her parents, if her parents are financially eligible and meet the categorical requirements.

8. Infant benefits: Within the first six months of the birth of a child, the child is eligible for a one-time benefit of $300 for a crib and clothing for the newborn.

9. Pregnant and parenting teens under 18 years receiving AFDC for themselves can get a clothing allowance of $150 in September of each year, along with their dependent children.

10. A pregnant teen who lives with a non-parent relative can choose to have her own AFDC grant or receive benefits with her relatives. If her relatives have other income, she can still receive AFDC either on her own, without counting any of their income.

11. A married pregnant woman or teen living with her husband is categorically eligible for AFDC although her husband is not eligible for benefits until the child is born. However, her husband's income and resources are counted in determining her eligibility.

12. If a pregnant woman or teen is not married but lives with the prospective father, his income is not counted, unless he voluntarily contributes to her support, until she gives birth. Once a baby is born, the father's income is counted in determining eligibility. If he or the mother have little or no income, the family can receive either AFDC or General Relief, depending on which program criteria they meet.

13. The pregnant woman or teen receives a one person AFDC grant as a pregnant woman. Upon birth, the AFDC may be available to the mother, father and child as long as paternity of the father is established and one of the parents has an incapacity or work history. If the family does not qualify for AFDC, the family should be eligible for General Relief.

Unemployed Parent Program

Parenting teens, or any parent in a two-parent household, who is seeking benefits under the Unemployed Parent Program, can establish the work history criteria through past employment including baby-sitting, snow shoveling, paper routes or any form of employment that can be documented. It must add up to not less than $50 in each quarter and meet other requirements of the UP program - 6 quarters of work, over a 13 calendar quarter period, ending within one year of application.

General Relief

General Relief is a state-funded program targeting "non-employable" individuals, two-parent families who do not have a work history, or have an incapacity, and children under 16 who do not qualify for AFDC for financial or categorical rules that do not exist in General Relief. Some examples relating to the teen population include

1. Pregnant women who are not eligible for AFDC for some reason, may be eligible for GR individual benefits, as "non-employable", if they are unable to work. (see#5 below)

2. Two-parent families with children, often teen parents who do not qualify for AFDC due to the work history requirements, may be eligible for GR benefits.

3. Children of parenting minors who have been terminated from AFDC due to "grandparent deeming" or "sibling deeming" may be eligible for GR benefits.

4. Students may be eligible for GR if they are attending school full time at a high school, vocational education program, or non-college education program, and are not eligible for AFDC. A pregnant teen woman in school, who is ineligible for AFDC may wish to apply for GR. If she lives with her parents, their income will be counted until she is 18.

5. Non-employable individuals who can medically verify that they are able to work less than 20 hours a week should apply, if ineligible for AFDC.

Note: Infant benefits are also available under the GR program, $300 is provided to infants less than 6 months of age for crib and clothing needs.

Food Stamps

This is a federally funded program that provides benefits mostly to families and individuals who are financially eligible, including pregnant women, teens, and teen mothers living on their own. The amount of food stamps is based on monthly income. There are exceptions. Pregnant and parenting teens should also apply for WIC, discussed in the Health Section.

Emergency Assistance

This is a state and federally funded program which provides assistance to families with children under 21 years, and pregnant women, to avoid the destitution of such child, or to provide living arrangements in a home for such child.

Benefits included in EA are emergency shelter of at least 60 days; first month's rent, security deposit, $150 moving expenses; utility, fuel and rent arrearage payments; payment for appliance repairs, and other disaster benefits.

EA is available for only one-thirty day period in any twelve months. EA income and resource limits are the same as the AFDC financial

eligibility guidelines. Any pregnant woman, pregnant teen, or teen mother who is homeless can apply for EA. If a pregnant woman is under 21, and lives with her parents, she is included in the household, and her income and resources are counted.

Homelessness and Shelters

Teens, including pregnant and parenting teens, are increasingly experiencing homelessness.

In 1984, the Department of Housing and Urban Development (HUD) conducted a study on shelter populations in the U.S. Approximately 22% of the homeless living in shelters at that time were under age 18. More than 66,000 children were living without permanent shelter, an amount that increases each month.

In Massachusetts, about one-half of persons housed in family shelters are adolescent mothers. In the past, pregnant teens have slightly outnumbered pregnant women over 20 years.

While some shelters give preference to single and very young mothers and their children, some do not accept single pregnant young women without children. Teen parents and pregnant women are given priority access to the Department of Public Welfare's contracted emergency shelters.

Families typically stay in shelters between 4 and 6 months, according to the Department of Public Welfare. The average stay for adolescent parents is 3-4 months, and for pregnant adolescents, 3-5 months.

Teen parents represent approximately 10% of the hotel/motel population in shelters in the state. In Boston, this figure is 22%. The Department of Public Welfare is targeting 30% of all new emergency shelter beds in the FY88 budget to this population.

In January, 1988, representatives from the Alliance for Young Families met with officials in the Shelter Resource Unit at DPW to discuss the development of emergency shelter beds specifically for pregnant and parenting teens. The Department will target seven areas of the state for the high numbers of pregnant teens and families in hotels and motels. The areas are Cape Cod, Boston, Brockton, Chelsea, Springfield, Malden, Lynn/North Shore, possibly Worcester.

Introduction

In Massachusetts, one out of every 5 children is poor. In Boston, one out of every 3 children is poor. The following is a list of cities and towns in Massachusetts with children less than 5 years of age living below 100% and 200% of poverty*

City/Town	Children Below 100% of Poverty Number	Percent	Children Below 200% of Poverty Est. Number	Percent
Holyoke	1,301	41.0%	1,999	62.9%
Boston	10,290	34.2	17,495	58.1
Lawrence	1,725	32.6	2,992	56.5
Springfield	3,254	30.9	5,618	53.3
New Bedford	1,849	27.2	3,664	53.9
Lynn	1,341	26.8	2,427	48.4
Worcester	2,461	25.7	4,513	47.1
Fitchburg	649	25.6	1,207	47.6
Fall River	1,536	24.3	3,437	54.4
Lowell	1,542	22.3	3,063	44.3
Pittsfield	706	22.3	1,351	42.7
Haverhill	669	21.5	1,326	42.6
Cambridge	840	21.4	1,709	43.5
Brockton	1,481	21.2	2,972	42.5
Somerville	756	18.9	1,667	41.8
Taunton	547	17.8	1,176	38.3
Quincy	624	16.3	1,282	33.4
Chicopee	538	16.2	1,282	36.6
Malden	436	15.0	1,004	34.5
Waltham	369	13.4	770	29.0
Medford	369	13.4	809	29.3
Weymouth	361	12.5	803	27.8
Framingham	371	10.8	774	22.6
Plymouth	301	10.2	898	30.1
Newton	194	5.2	548	14.8
Massachusetts Totals:				
	52,119	15.5	112,798	33.5

In November, 1986, a report of the Massachusetts Caucus of Women Legislators' Task Force on Women in Poverty issued a report of it's findings," "Public Assistance Programs for Poor Women in Massachusetts". The report discusses the overall increase in poverty in the United States, with contributing factors including

*Source: Title V Maternal and Child Health Services Block Grant. Report of the Secretary of Health and Human Services in Mass., 1985. Governor Dukakis, Exec. Office of Human Services, Dept. of Public Health.

Introduction

the sharp drop in the purchasing power of the minimum wage, a steady decrease in higher paying manufacturing jobs combined with a large increase in lower paying service industry jobs, and discrimination against people of color.

The report states that "poverty has increased among women because of the increased divorce rate, a lack of adequate child support payments, discrcmination against minorities and women in types of jobs and pay scales, lack of affordable child care, reduction in programs to assist the working poor, the decreasing value of welfare benefits, and the increasing costs of housing. The report also states that 28% of working women earn less that $4.00 an hour. In Massachusetts, 65% of new jobs were created in the retail/service sectors which have low wages. Participants in the state's Employment and Training Program are making a median salary for full time work of $8,775. The poverty level for a family of three is $9,100.

An analysis of the public assistance programs contained in the report conclude that the programs as currently reulated and administered are:

1. Inadequate to meet the physical needs of growing children.

2. Hampered by rules and regulations making it more difficult for eligible and needy families to get the help they need.

3 Unable to provide sufficient support services to help all those who want to become self-supporting to achieve their goals.

The study concludes that growing calls for welfare reform should not permit prevention of the federal and state governments' from addressing the basic changes required for those needing assistance to provide for their families. Among other findings of the Task Force Report are that in Massachusetts, female heads of household and their children represent 48.8% of all those living in poverty. A family on AFDC in the state lives 37% below the poverty level. Both the working poor and the welfare poor face a constant struggle to feed and clothe their children and provide a decent, secure shelter for them. Average wages for women who work are 64% of the earnings of males. Single women are especially negatively affected by this factor. Even with the FY87 10% increase, a family of three only had $476 a month.

The report provides a comprehensive review of all public assistance programs in the state, with a breakdown of problem areas in AFDC, General Relief, Medicaid, Employment and Training, and Housing. A broad range of specific and general recommendations are contained in the report of the Task Force on Women in Poverty. The Task Force was chaired by State Representative Marjorie A. Clapprood, with Barbara Talkov as Executive Director of the Women's Caucus, and Helen Patterson as Project Director of the Task Force study and report. The Task Force has reconvened to review current data and information, update the report, and plan new initiatives. The present chair of the Task Force os State Representative Carmen D. Buell.

Task Force on Women and Poverty

In May, 1987, a report prepared for the Women's Caucus Task Force on Women and Poverty was issued through the initiative of Representative Buell, as a companion to the initial report. The report, "Massachusetts Women and Poverty: Characteristics of Age, Race, Education, Family Status, Poverty, and Labor Force Status" was prepared by the Massachusetts Institute for Social and Economic Research (MISER) at the University of Massachusetts at Amherst. The Task Force recognized the need for more detailed information in determining how poverty affects women and children in various areas of the state. According to the authors, "This report presents the most detailed information currently available about women and poverty for each of the 351 cities and towns in Massachusetts." Data is included about poverty and families, families with a female head of household, for all females by age, and for children under 18 years. Labor force status for female family householders above and below poverty is also presented. The following information on children and poverty is from the report, compiled through the office of Representative Buell.

	TOTAL CHILDREN UNDER 18	% CHILDREN UNDER 18 IN POVERTY	# OF CHILDREN IN POVERTY
Boston	121,637	30.1%	36,491
Brockton	28,672	17.8%	5,160
Cambridge	14,891	19.9%	2,978
Chelsea	6,714	38.4%	2,551
Fall River	25,003	22.1%	5,501
Holyoke	12,296	32.4%	3,935
Lawrence	18,227	30.2%	5,468
Lowell	25,560	19.9%	5,112
Lynn	20,381	21.5%	4,484
New Bedford	25,875	25.7%	6,728
Springfield	42,057	29%	12,197
Worcester	38,299	22.1%	8,426
		TOTAL	99,030
Massachusetts	1,492,090	12.9%	193,972

These 12 cities have over 50% of the children in poverty in Massachusetts.

DPW statistics show that 168,000 of AFDC recipients are children.

86% of poor children in Massachusetts are on AFDC.

Task Force on Women and Poverty

The following chart gives the cities and towns in Massachusetts with the highest percentages of families living below poverty. Data sources are the M.I.S.E.R. report. Only those cities and towns haveing 10% or more of families living below poverty are stated.

City/Town	Percent	City/Town	Percent
Gay Head	24.1%	Brockton	11.3
Chelsea	19.7	Lowell	11.3
Wendell	19.2	Peru	11.3
Heath	18.1	Salisbury	11.3
Lawrence	17.0	Worcester	11.2
Boston	16.7	Truro	11.1
Holyoke	16.6	Cambridge	11.0
Sandisfield	16.1	Brookfield	10.8
Suffolk	15.8	Amherst	10.7
Springfield	15.6	Huntington	10.4
Provincetown	14.1	Wareham	10.4
Fall River	13.1	Ashfield	10.2
Cummington	12.5	Conway	10.1
Lynn	12.3	North Adams	10.1
Brewster	12.0	Charlton	10.0
Goshen	11.4	Middleborough	10.0
New Braintree	11.4	Southbridge	10.0
		Warwick	10.0

Women and Poverty and Teen Pregnancy

Representative Fiero, a member of the Task Force on Women and Poverty, analyzed statistical data from the Teen Pregnancy Report and the Women and Poverty report, and developed comparative findings on the teen pregnancy-poverty cycle. Cities and towns in the state with the highest percentages of children in poverty represent many of the same cities and towns with the highest teen birthrates. The top twelve cities in the percentage of children under age 18 in poverty represent 50 % of all children in poverty in the state. These same twelve cities also represent 52.5% of all teen births in the state.

Representative Fiero stated that "the children of these teen parents often experience a life of poverty, delayed development, and school and health problems."

The following is a comparative listing, prepared by Representative Fiero, of the cities and towns with the highest percent of children under 18 in poverty, and the cities and towns with the highest birthrates in 1985.

PROGRAMS AND SERVICES; MASSACHUSETTS

%Children under 18 in poverty		Teen Birthrates	
Chelsea	38.4%	Lawrence	68 per 1,000
Holyoke	32.4	Holyoke	59.4
Lawrence	30.2	Chelsea	41.6
Boston	30.1	Fall River	40.0
Springfield	29.0	Lowell	39.1
New Bedford	25.7	Springfield	38.4
Fall River	22.1	New Bedford	35.3
Worcester	22.1	Lynn	34.2
Lynn	21.5	Brockton	34.1
Cambridge	19.9	Boston	30.6
Lowell	19.9	Fitchburg	29.4 (not in poverty list)
Brockton	17.8	Worcester	27.9
		Cambridge	13.1 (ranks 19th in state in teen birthrates)

These 12 cities combined total 53% of all teen births in Massachusetts in 1985.

Up to Poverty and Beyond Campaign

In 1970, the Mass. welfare grants, including AFDC and GR, were roughly equivalent to the federal poverty line. At the same time the cost of living increased, the welfare grants were level-funded or increased by 3% or 4% each year.

In 1984, Massachusetts grants were 40% below the poverty line, and Massachusetts ranked 40th among the states in keeping public assistance in pace with inflation.

The Up to Poverty and Beyond Campaign was formed by welfare recipients, advocates and other support groups and organizations. Members of the Legislature have filed legislation addressing welfare and associated issues, and have worked with the supporters of the campaign. In FY86, there was a 9% increase in grants, in FY87, there was a 10% grant increase with a 15% rental subsidy for those in private housing. As a reduction in food stamps was required by the federal government-$1 for every $3 in cash increase - the grant increases remained insufficient. For FY88, budget appropriations are $521,775,704, a 7% COLA and $0 a month rent supplement.

According to the Women's Campaign for Social Justice, "The Campaign demands a benefit level that will allow families to raise children free from hunger and homelessness. The Campaign is raising the question of how much it costs to live in Massachusetts for all families, whether they receive AFDC benefits or work full-time. The debate focuses on income, and points out that minimum wages are insufficient for families to live on, as are AFDC grant levels. The major groups working on the Up to Poverty Campaign are the Women's Campaign for Social Justice, the Coalition for Basic Human Needs, Mass. Coalition for the Homeless, and Mass. Law Reform Institute Institute. Other groups are also supporting the Campaign.

Superior Court Ruling on AFDC

Chapter 118, s.2 of the General Laws requires that AFDC grants be sufficient to allow a parent to raise her, or his, children properly in their own home. In June, 1986, Superior Court Judge Charles Grabau rules that current AFDC grants violated the legally required standards. The Judge also ordered the administration to determine a sufficient welfare grant level based on the actual cost of living.

In August of 1986, in response to the court order, the Department of Public Welfare determined three minimum levels of income that families need to raise children adequately in Massachusetts:

$11,117 for a family of three in private housing in metropolitan Boston
$10,373 for a family of three in private housing outside of Boston
$ 7,745 for a family of three in public or subsidized housing throughout Massachusetts

In September, 1986, EOHS and DPW released a report that they had been ordered to prepare. The report stated that for a mother with 2 children to raise her family properly in her own home, she needs at least $11,117 a year, if she lives in private housing. In August, 1987, the Massachusetts Supreme Judicial Court ordered the administration to request an appropriation adequate to pay these benefits.

Date from the Mass. Coalition for the Homeless and the Coalition for Basic Human Needs indicates that all families need at least $9,300 a year - $775 a month, the federal poverty level - while those in private housing need at least $250 more a month for rent.

Through the lawsuit, filed by the two Coalitions, Judge Grabau ordered the state to develop a new standard of assistance, which is the basis on which the state determines eligibility for welfare benefits.

According to Mass. Law Reform Institute, "The SJC ruling reversed the Superior Court order insofar as it required that the AFDC Standard of Need be set at the amount determined by the DPW as necessary to enable a family to live in their own home. Under the SJC ruling, the legislature has the discretion to set the Standard of Need at whatever level it finds appropriate." Groups objecting to the levels set plan to continue the campaign.

Joint Committee on Human Services

In March, 1988, the Joint Committee on Human Services and Elderly Affairs, chaired by Representative Paul Kollios, and Senator John Houston, issued a report, "Closing the Gap for Children in Need: A Special Report on the FY88 Standard Budgets of Assistance for Families with Dependent Children". The report, and accompanying legislation, propose a plan for a three-year schedule to raise welfare benefits to the standards of need recently defined by the Department of Public Welfare. The proposal would cost the state $30 million next year.

The report details the gap between the cost of basic necessities and the amount of public assistance available to single mothers with children.

The report recommends a 9.1% increase in the basic AFDC grant next year, together with a $30 a month increase in the rent allowance for private housing tenants on AFDC and a $20 a month food allowance to offset the loss of federal food stamps.

The Committee proposed legislation to make the state eligible for federal reimbursements to offset nearly $19 million of the cost next year, by transforming some current state aid into joint state-federal programs. Other legislation approved by the Committee would enact a firm schedule for bringing AFDC benefits up to the new standards by 1990, and would then index aid to the cost of living.

The Committee report gives comprehensive recommendations for raising families to an acceptable standard of living, with adequate housing, food, income, fuel, over a three-year period.

Excerpted from a statement issued by the Joint Committee on Human Services and Elderly Affairs.

CHILD SUPPORT ENFORCEMENT
FEDERAL

In 1974, Congress passed Title IV-D of the Social Security Act, which estabilised child support enforcement programs for the purposes of "enforcing the support obligations owed by absent parents to their children, locating absent parents, establishing paternity, and obtaining child support". After it's passage, states were then required to provide child support enforcement services to all AFDC families, and non-AFDC families who requested services. AFDC recipients were required to cooperate.

In 1982, the program colleced $1.8 billion, $787 million of which were AFDC collections, representing 6.8% of the AFDC benefits paid. The 1982 enforcement caseload was approximately 7 million. Only 1.5 million was non-AFDC. In 1982, the program located 782,000 absent parents, established 174,000 paternities, and established 469,000 support obligations.[485]

In an information brief, "Child Support Notes", published by the National Child Support Enforcement Reference Center, Office of Child Support, is stated that "In 1983, unpaid child support totaled $3 billion, excluding arrearages owed from previous years". States have found ways to fund state and local child support programs, refine support order establishment and enforcement techniques, and oversee child support operations.[486] The Child Support Notes give varying methods and techniques that states are utilizing to enforce, collect, and maintain child support enforcement.

The federal Child Support Enforcement Amendments of 1984 gave states the tools they need to collect support. By 1987, states must:

1. Withhold the income of a parent who falls behind more than one month in paying support. States can go beyond this standard.

2. States must intercept tax refunds to parents behind in support payments.

3. Credit agencies must be informed if a parent is in arrears on support.

4. States must lengthen the time for establishing paternity to 18 years. "Often teen mothers fail to pursue paternity, losing sight of the future earning of the father and his obligation to support his children."[487]

5. Parents' medical coverage must be available to the child.

6. States are required to see that support orders are established and enforced on a timely basis so children do not wait months or years for support.

The U.S. Department of Health and Human Service's Office of Child Support Enforcement estimates that the first two practices are the most effective ones that states can adopt. States must also have statewide, objective, numerical guidelines for determining support obligations by October 1, 1987. The guidelines are needed "to increase the amount of awards and to make awards uniform".[488]

A U.S. Census report states, "Out of 8.7 million women raising children on their own, more than half receive no financial help from fathers. A million of these women are unable to collect from court-awarded support. Out of 3.7 million mothers without court-ordered awards, the vast majority cannot locate the father or establish paternity". Two-thirds of white women had awards, as compared to only one-third of black women.

According to an article in State Government News,[489] the average award received in 1983 was $2,340, which is less than half the cost of raising a child. Studies indicate that the standards of living of the parent keeping the child falls lower following a divorce, while that of the non-custodial parent increases.

While most states have upgraded their child support enforcement laws and regulations to comply with federal laws passed in 1984, many programs are only marginally effective. Some states, however, do take a high profile approach. The article in State Government News quotes Ann Kolker of the National Women's Law Center, "Insufficient resources remain in many states a serious barrier to the provision of strengthened and improved enforcement remedies." On the average in 1986, states collected $3.31 per $1 spent on administrative costs of collection, with some states collecting higher amounts.

The consequences of family disruptions such as single parenting, divorce and separation, frequently force children to live on welfare rolls, a life of poverty and deprivation, and loss of social, economic and educational services vitally needed. "Children pay the price for their parents divorce, abandonment, and separation. The results are higher welfare costs and lost futures for children.[490] One birth in five is to an unwed mother. 90% of single parent families are headed by women, and nearly half of all female-headed families live in poverty.[491]

According to the Urban Institute Report on Welfare Dependency and Teen Pregnancy, some states have made the decision not to hold the father liable for support until they are 18 years old. Others pursue the fathers immediately. Since adolescent fathers do not show much short-term promise of providing economic support for their children, their cases fall to the bottom of the pile. The report points out that "There is a reluctance of adolescent mothers to initiate paternity proceedings against the father because they don't want anything to do with the father, or are afraid they may alienate the father by court proceedings. Preliminary findings of a study on adolescent fathers shows that AFDC regulations are widely perceived as punitive, and paternal acknowledgement can have negative consequences. Many mothers did better economically if they did not pursue support from the father.[492] There is no data available on the incidence of paternity adjudications and child support orders by the age of either parent.

The feelings on the part of many professionals are that, with adolescent mothers, child support enforcement is either irrelevant or too intrusive. Others feel that is child support for mothers were enforced, the public sector cost of dependence will decline. The argument is that "if fathers were made to bear

responsibility for their children, they may be more careful about producing these children. Child support should be enforced as a model of responsible adult behavior."[493] Another issue for the extended family members of the mother is that if child support were enforced, the mother would lose her family's support and the provision of child support would entail visitation rights for the father. Many fathers do assist their families informally.

The Urban Institute Report suggest that paternity adjudication and support enforcements should be coupled with a strong set of support services for fathers, which would lead to better economic outcomes for their children.

According to the report of the National Research Council, Risking the Future: Adolescent Sexuality, Pregnancy and Childbearing, teen fathers are unlikely to be able to make any substantial contributions for the support of their children while in their teens. "There has been renewed interest in the enforcement of child support for the fathers of children born to teen mothers, to provide additional financial assistance to young mothers and as a means to increase the sense of parental responsibility." The report points out that while the income of fathers may be low at first, when children are young, it may increase over time, and have long-term positive effects on the children.

While many fathers of the children of teen mothers do have full-time jobs, with higher levels of wage earnings and income from these jobs, especially older fathers, many teenage fathers, and fathers in their early twenties, are in low paying jobs and are unable to adequately support their families. A report from the Children's Defense Fund, "Declining Earnings of Young Men: Their Relation to Poverty, Teen Pregnancy, and Family Formation", May, 1987, states that "The erosion of employment opportunities and wage levels for young men seriously jeopardizes the formation and the well-being of young families. The average earned income for a male between the ages of 20 and 24 dropped by roughly one-fourth between 1973 and 1984. Sharp declines in the percentage of young men who earn enough to lift even a small family out of poverty have taken their toll on marriage rates among young adults, including those who bear children at an early age. Out-of-wedlock births increased by one-third during the 1973 to 1984 period." The report also points to other factors influencing the income of young families:

* While the earnings of young female workers declined only slightly during the past decade, they remain far below male earning and are frequently inadequate to support families.

* Between 1973 and 1984, the average real annual earnings among males ages 20 through 24 fell by nearly 30 percent-from $11,572 to $8,072 in 1984 dollars.

* While this sharp drop negatively affected all ethnic groups of young males, young black men suffered the most severe losses.

* The worst hurt by these trends have been the young people with the least education, including high school dropouts and other youths with weak basic academic skills relative to their peers.

CHILD SUPPORT ENFORCEMENT
THE CHILDREN OF TEEN MOTHERS

A more complete discussion of the economic consequences of early childbearing, the poverty influences that are casual factors in the determination of early childbearing, and the income levels and job earnings of young people, along with the negative effects on children, is contained in Section

While many fathers of the children of teen mothers are themselves teens, there are studies giving preliminary findings that between 40% and 50% of the fathers are older men, many by several years. Many of these men are, and have been, working at full time jobs for many years. Many also work at low-paying jobs, and many work inconsistently or are unemployed. Some contribute to the support and care of their children, others do not. A further discussion of the ages of the fathers is in Section 1.

The report, Risking the Future, states that there is little existing research or program experience to guide policy-making in this area. Further efforts are needed in this area, and further study on the effect and effectiveness of child support enforcement for the fathers of the children of teen mothers. The report encourages the development of educational and job training programs for young men of all ages. "Efforts should be made to link child support to education and work requirements in the form of registration with state employment services and participation in job training and job search activities as well as work opportunities."

A statement from the Governor's Conference, "Bringing Down the Barriers to Opportunity" on Child Support Enforcement, indicates that 7 out of 10 single parents receive little or no child support. Further, inadequate child support results in a significant reduction in the standard of living for the parent who retains custody. Adequate child support can eliminate a major factor contributing to the growing number of children living near or below the poverty line. The increasing incidence of divorce and separation and teen pregnancy means that "single parent families are the fastest growing segment of society".

The Massachusetts Department of Revenue, Child Support Enforcement Division, issued a report in October, 1987, which consisted of an operational review of the state's CSE Program. The report states, "The vast majority of the families eligible for child support are headed by women, and their economic situation is grim. Children in single parent households enjoy barely a quarter of the income of children in two parent families." The report points out that in 1985, the median income for female-headed households in Massachusetts was $10,002, as compared to $39,500 for a two-parent family. Also, "Where the children were under the age of six, the median income for female-headed households dropped to $5,616. Fully 55% of children in female-headed households live below the poverty line." While many factors can contribute tc these problems, lack of child support "plays the most significant role in the rapid descent into poverty."

The report states that a study in California found that one year after a divorce the standard of living of the custodial parent, usually the mother, and children declines by an average of 73%, while that of the non-custodial parent increased by 42%.

CHILD SUPPORT ENFORCEMENT
MASSACHUSETTS

According to census data, only 58% of the households headed by singly women have child support orders, and of those, fewer than half receive all that is owed to them. In 1983, the average amount of child support received per household was just $2,341 a year, or $6.41 a day.

In 1985, Governor Michael Dukakis established a Child Support Commission to address the problems inherent in the child support enforcement system, and to recommend changes to improve effectiveness in enforcement of child support. The Commission reported to the Governor in October of 1985 that the system was experiencing some major problems, including:

1. Fragmentation: Though there were many parties involved in the CSE system, no single agency was empowered to define the roles, coordinate activities and invoke accountability.

2. Inconsistency: In the absence of guidelines, there were wide disparities in the system.

3. Inadequate Provision of Services: While Welfare provided child support services to Aid to Families with Dependent Children, there was no single agency equipped to help those not on AFDC obtain child support.

4. Lack of Public Notice: There were no easily understood printed materials available to guide people through the system.

5. Failure to Take Advantage of Available Enforcement Tools: Though enforcement tools, although limited, were available, the CSE system failed to take full advantage of them.

The Department of Revenue report outlines comprehensive recommendations for action to improve Child Support Enforcement in the Commonwealth.

In july, 1986, the Governor signed into law Chapter 310 of the Acts of 1986. The legislation, filed by State Representative Susan D. Schur (D-Newton), requires:

* The Massachusetts Trial Court to promulgate uniform guidelines for the establishment of fair, equitable, and adequate support levels of child support.

* Automatic wage withholding from the paycheck of the non-custodial parent for most child support orders.

* The expansion of child support services to all custodial parents, to help in the establishment and enforcement of support orders.

* A simpler, non-criminalized procedure for the establishment of paternity.

CHILD SUPPORT ENFORCEMENT
MASSACHUSETTS

* Administration for child support enforcement transferred from the Department of Public Welfare to the Massachusetts Department of Revenue, which will develop centralized collection, accounting, and payment systems, in addition to providing comprehensive child support enforcement services to all who are entitled.

According to Representative Schur, inherent in the guidelines is the basic premise that all parents are expected to pay child support for their children. With regard to teen parents, while there is an understanding about their lack of ability to pay for the care of their child, there should be a standard enforced that sets a pattern of payment, no matter what the age of the father, or mother, and even in the absence of a court order. "Token orders" could be established to set the pattern of responsibility until payments can begin at a later period of time, when the teen parent is older, land employed, and able to provide for the care of the child.

In November, 1987, the Massachusetts Legislature approved a bill making it easier for the Department of Revenue to seize property from people who fail to make child support payments. Under the provision of this bill, the state can, without seeking court approval, seize homes, cars, boats, bank accounts, and other property of non-custodial parents who do not make court-ordered payments. The bill also allows the state to impose interest on delinquent payments. The Department of Revenue can also intercept tax refunds for non-payment of child support.

The Department of Revenue, Child Support Enforcement Division, recently stated that major changes have already taken place. Child Support Guidelines have been promulgated, more than 50,000 child support delinquents have been targeted for income tax refund intercept, and child support collections, both AFDC and non-AFDC are increasing. Child support-related AFDC case closings are up 37% over last year.

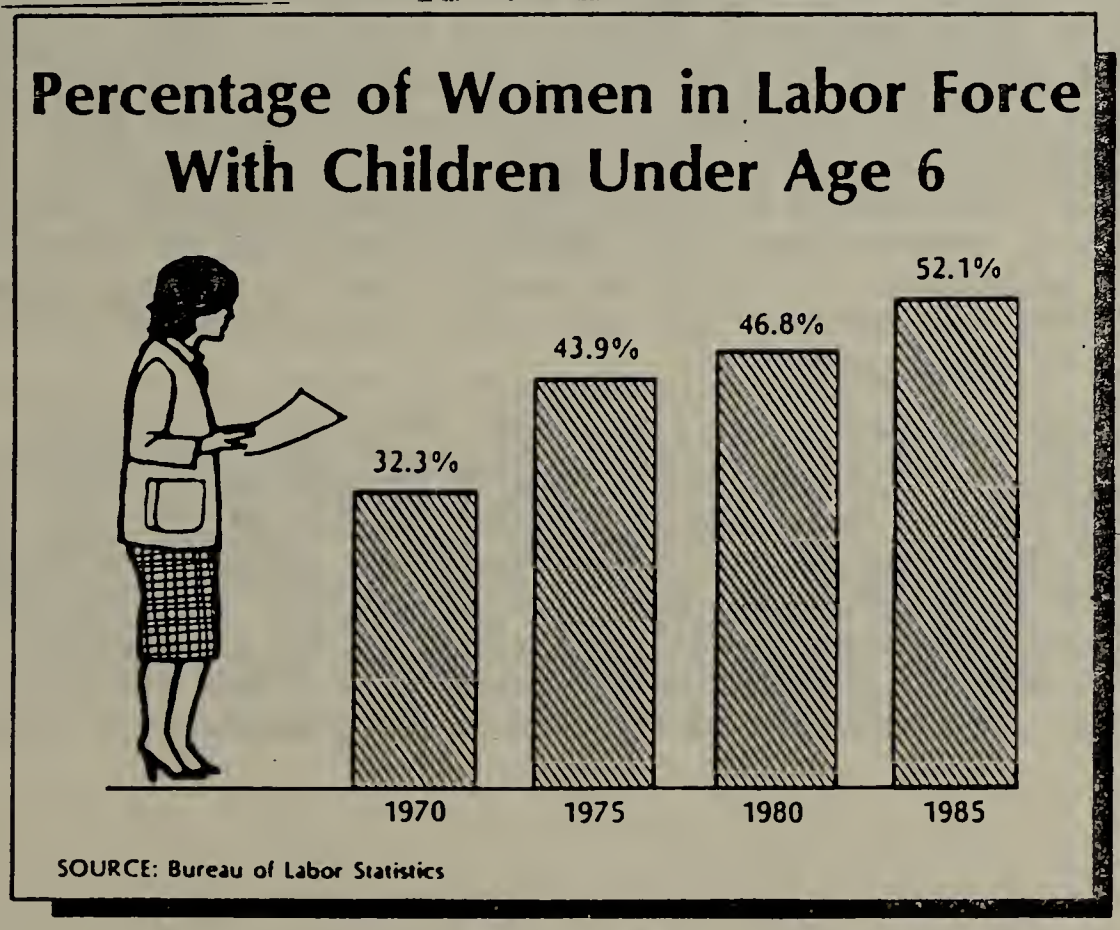
The Department is responsible for collecting more than $100 million in delinquent child support payments. In 1986, $111 million was collected, half of which was collected on behalf of welfare clients.

The Governor's FY88 budget request commits the Department of Revenue to a strong advocacy role for children and custodial parents, and provides for an automated system to effectively handle child support that is collected and distributed.

Overview

The availability of child care is one of the most critical determinants of whether or not a teen parent is able to continue in school, participate in a work-study program, or enter into job training and employment skills programs. A high school diploma is the first step towards personal, social, and economic self-sufficiency and independence. Throughout pregnancy, childbirth, and during the early parenting years, school-age mothers experience a wide range of needs that are constantly changing. When young mothers become pregnant, deliver their child, and attempt to return to school, these needs become even more extensive. Continuation of education is a very difficult, often impossible task for most. One of the most critical needs, and one that remains a seriously unmet need, is that of the provision of day care and transportation to teen mothers.

Early childbearing is a major cause of young mothers dropping out of school. The consequences of dropping out, combined with a lack of work experience and the limitations imposed by child care and other responsibilities, severly hamper and impede the adolescent mother's efforts to participate in the labor market. According to an article in Human Services in January, 1986, in 1970, 32.3% of women in the labor force had children under six. In 1985, 52.1% did. Most of these working mothers will require child care services. Many are, or were, teen mothers. The following chart states the percent of women in the labor force with children under six, from 1970 to 1985.



Source: Bureau of Labor Statistics. From Human Services, Jan. 11, 1986

Neither the teen mother nor father are likely to have the opportunities to learn and acquire the educational, vocational, or employable skills necessary to enable them to work towards economic independence. According to a recent report from the Senate Office of Research in Washington, D.C., to Senator Gary Hart, entitled, A Special Report on Adolescent Pregnancy, "adolescent parents are more likely to have heavy family responsibilities and are not as likely to acquire the work experience necessary to secure jobs in higher socioeconomic brackets. Further, if an adolescent does find a job, it is likely to be of lower socio-economic status, resulting in lower hourly wages and annual earnings. The daily financial problems of adolescent parents are further intensified by their early parenting in that early childbearers, especially those who drop out of school, are likely to have more children than older mothers."

One way to address, and to help alleviate this problem, and reduce the predictable outcomes stated, is to facilitate the return of many teen mothers, and fathers, to school by accessing them to day care and transportation for themselves and for their children. According to a report by the National Conference of State Legislatures on initiatives addressing teenage pregnancy and parenting, "the lack of adequate day care is the teen parent's single greatest barrier to participation in educational programs. Most teen parents, especially young women who are raising children alone, cannot afford typical day care services."

The Academy for Educational Development published a report entitled, In School Together: School-based Child Care Serving Student Mothers. In the foreword by Marian Wright Edelman, of the Children's Defense Fund, is stated, "Obtaining child care is difficult for young mothers who are also likely to be without financial resources to purchase services they need. Teen parents with infants do not have a ready supply of child care options available to them. Most high schools do not offer child care programs, and teens must seek child care in communities." Ms. Edelman stated that these services are hard to locate and obtain, as slots are sought after by working mothers. She cites the fact that teen parents with low or no incomes must receive help in meeting the costs of child care.

Studies identify child care as one of the most significant unmet needs of young parents. In 1982, Public Health Reports stated that in 1978, a nationwide study of teen mothers and their babies in 125 large cities found that the primary problem for young mothers was insufficient infant child care. If day care is not provided, most teen mothers will drop out of school to care for their children, or will not return at all after birth. Staying in school and completing education is connected to teens' abilities to become independent and productive adults, and to the prevention of repeat pregnancies.

PROGRAMS AND SERVICES: CHILD CARE

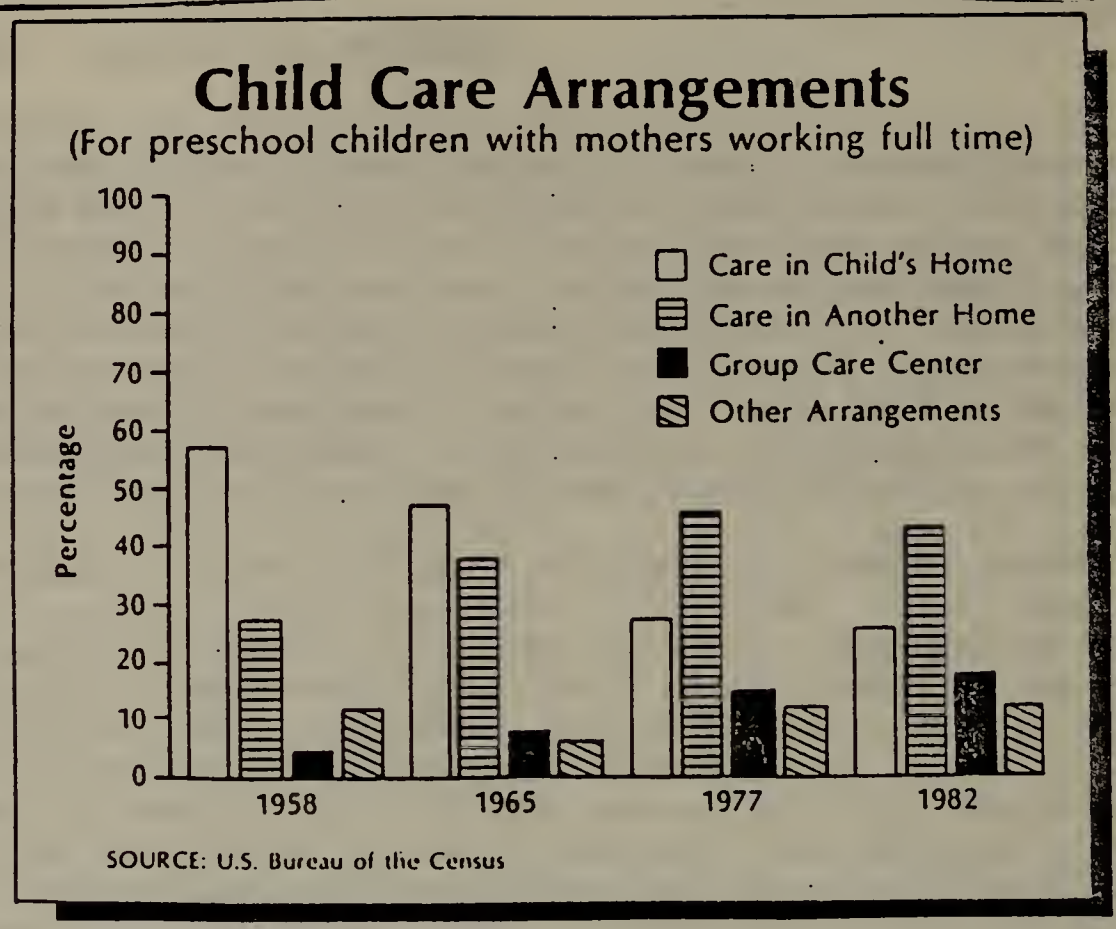
Surveys of services offered to pregnant and parenting teens indicate that child care is one of the services least provided, at the same time it is one of the highest priorities of need. According to a report from The Alliance for Young Families in Boston, "day care has been consistently identified by researchers, providers, and teen parents alike, as a critical service whose provision and utilization can have a positive impact on young parents. It contributes to their ability to return to complete high school, participate in job training programs and employment, and developes parenting skills. Indirectly, it can contribute to reducing subsequent pregnancies and births."

Few teenage mothers have resources to enable them to return to, and complete, high school. Nationwide studies consistently state that provision of day care is positively related to educational attainment, job training, experience and employment status. Enhancing opportunities of young mothers through day care services has long-term beneficial effects on both the individual and social costs of early childbearing. From both an interventive and preventive perspective, the availability of child care services to teen parents in need is an important step in supporting family development and in promoting the economic self-sufficiency of this population. Many teen parents are inexperienced in parenting roles, and require special attention. They need coordination of child care routines with home care duties, and also need special services such as health care, social and developmental services.

Accessing school age mothers to school, facilitated by day care and transportation, improves their life options and experiences, and expands their resources and choices, rather than enforcing a life of social and economic isolation, loss of self-worth, and lack of employable skills - all of which destines many young women to a life of personal, social, and economic dependence, an erosion of self-confidence, and continuation for the teen mothers and their children in a generational cycle of poverty.

Child Care Arrangements

According to the report by the National Research Council, Risking the Future, "Adolescent mothers who remain in their original households had family members and extended family members to help care for and babysit for their children. But many grandmothers work, and for adolescent parents, independent child care is essential. It must be low cost, available, and accessible. The following chart indicates child care arrangements for preschool children with working mothers, from 1958 to 1982. The chart indicates the decline in care in the child's home, and an increase in the use of group care.



Source: US Bureau of Census, from Human Services, Jan., 1986

Costs of Child Care

The Children's Defense Fund found that there were wide variations in costs of child care in a survey conducted in 49 states in 1985. Out of home care for one child can range in cost from $1,500 to $10,000 a year, with the majority of parents paying $3,000 a year. This amount is clearly beyond the means of low income families. The survey results stated that in most states, funding is severly inadequate to meet the child care needs of young parents. A further discussion of costs will be presented in the section on day care in Massachusetts.

Location and Organization of Child Care

According to the report of the National Research Council, "Child care services can be provided in several different organizational contexts, including high schools and alternative schools, youth servicing agencies, and neighborhood social service centers, local churches, free-standing for profit and nonprofit child care facilities and family day care homes.

Several school-based clinic programs and alternative school programs have included on-site child care or child care referral services as a component of their servicing package. Some require teens to participate in their children's care by spending time each day, or during the week in the child care center, to gain experience in caring for their children, and other children.

PROGRAMS AND SERVICES: CHILD CARE

Caring for children of all ages helps teens understand the varying needs and developmental stages of children. In many programs, teens receive counseling and instruction on basic care, feeding, infant and toddler stimulation, parent-child communication and interaction, and recognition of health and developmental difficulties. Some programs also have trained mental health workers on site to observe and provide services. Some schools offer credits towards graduation. Most school-based child care is funded through Title XX of the Social Security Act. Some school officials say that day care is too costly, and is outside their function. Some school systems provide transportation for mother and child, others say that busing has too many restrictions to provide transportation.

On November 17, The "Act for Better Child Care Services of 1987" was introduced in Congress. The bill would allocate $2.5 billion for the expansion and improvement of child care systems, and is sponsored by Senator Dodd (D-Conn.) and Representative Kildee (-Mich.). The bill encourages (no mandate) states to participate in a new state-federal partnership. Appropriations to each state that participates would be based on per capita income. The state would provide a 20% match.

If passed, Massachusetts would receive $33 million: $22.5 million in subsidies for parents; $3 million to expand part time programs; and $4.5 million toward the enhancement of the state child care systems. This would include Child Care Resource and Referral, regulatory enforcement, training, grants for health and safety improvements, wage upgrading.

The bill has gained support among 85 national organizations, including the Childrens Defense Fund, United Way, American Federation of Teachers, and the American Public Welfare Association. Massachusetts Congressmen who have signed on are Chet Atkins, Barney Frank and Ed Markey. Massachusetts ABC Coalition had the first of three information-strategy meetings on November 18. A media campaign has been initiated, and a rally is planned to support the bill on May 14, 1988.

Above excerpted from information sheet from Mass. Caucus of Women Legislators.

PROGRAMS AND SERVICES: CHILD CARE
MASSACHUSETTS

According to the report, In School Together, a 1979 survey of 100 teen parents in the Boston area conducted by the American Institute for Research, found that child care assistance was a critical service needed by teen mothers.

In 1980 a study conducted by the Alliance for Young Families in Boston found that 50% of young parents in their sample lacked consistent child care within their family networks. The "majority of the respondents viewed child care as essential to their participation in school, vocational training or work, and indicated that they would accept child care outside their families if it were available, and that they would participate in high school".

According to information from the Child Care Coalition, and the Metro Boston Child Care Network, "Child care is the key to economic independence for women, providing the crucial support which allows working families to maintain jobs and independence. Without access to affordable, quality child care services, parents are faced with difficult decisions. They must either pay the prohibitively high cost of unsubsidized care, use poor quality unlicensed care, or leave work to care for their children, an option which may force families to go on welfare. Children need and benefit from high quality early childhood education."

On January 22, 1985, Governor Michael S. Dukakis announced the Governor's Day Care Partnership Initiative, "a two-year program to strengthen and expand high quality, affordable day care for the families of the Commonwealth of Massachusetts." The workplan for the Initiative was prepared by the Governor's Day Care Partnership Project, chaired by Joan Quinlan, the Governor's Advisor on Women's Issues, and Senator Gerard D'Amico, co-chair of the Legislature's Committee on Education, and Project Director, Sheryl Adlin.

The report presented thirty recommendations for increasing supply, improving quality, making day care more affordable and improving coordination among the state agencies responsible for day care policy, purchasing and licensing. The recommendations began with an initiative of a statewide network of child care resource and referral agencies to address supply, quality and resource issues locally.

According to the Final Report of the Governor's Day Care Partnership Initiative: Partnerships for Day Care, June, 1987, from the Governor's Office of Human Resources, in 1980, 52% of all Massachusetts women were in the work force. Among women with children under age 6 years, 41.8% were employed outside the home.

Through the efforts of Governor Dukakis and the Massachusetts State Legislature, state spending for day care grew by 50% - from $67.1 million in FY 85 to $101.1 million in FY 87, with over 90% of the increase marked for the purchase of day care services for low income families or families in crisis.

As of December, 1986, the number of licensed day care places for children was 112,971. In the beginning of 1987, Massachusetts was subsidizing day care through vouchers for 8,329 children of former or current Aid to Families with

Dependent Children (AFDC) recipients, particularly those participating in Employment/Training (ET) CHOICES programs. Day care for another 13,524 low income families is subsidized by the state. The state also subsidized day care for 3,988 children with protective, preventive, or special needs, through Supportive Day Care. Massachusetts currently has 1,850 licensed day care centers, and 9,400 licensed family care homes. Between December, 1984 and December, 1986 infant enrollment in day care grew by 25%, todler enrollment by 10%, and pre-school enrollment by 12%. There was no increase for special needs children.

Purchase of Day Care Services

According to a report, How Does Your Community Grow?, two Massachusetts state agencies, the Department of Social Services and the Department of Public Welfare, purchase day care services. "In 1984 there were approximatley 22,125 children receiving state-subsidized day care, 17,295 through DSS and 4,830 through DPW's voucher day care for Employment and Training participants." The report states that the day care budget then was $64 million, and estimated that only one-sixth of eligible families receive subsidized services. Many families that do receive such services pay a fee for services themselves, based on a state sliding fee scale.

DSS and DPW purchase the majority of state-subsidized day care services from a variety of providers - center-based programs, family day care arrangements, babysitters. Reimbursement is also available through the Job Training Partnership Act (JTPA), and through local Community Development Block Grant funds. Some day care programs in public schools are funded primarily through the Public/Private Partnership Program of DSS. The Office for Children licenses and monitors all facilities that provide day care for children, except those located in educational institutions.

The DSS purchases day care through contracts with service providers, which fall into two categories, Basic Day Care and Supportive Services Day Care. According to the report from the Alliance for Young Families, Uncertain Futures, Basic Day Care is available for families with work and/or training needs who meet the income eligibility criteria. Supportive Services Day Care is used for families with children who need protective or preventive care of who have special needs.

DSS contracts with the Public/Private Partnership Program which allows for 75/25 match of state and private funding for day care provision and information and referral. Adolescent parents may obtain babysitting services, which are reimbursed by the State on a per diem basis.

The Department of Public Welfare provides day care on a voucher basis for recipients of AFDC, who are in Employment and Training programs. ET provides limited resources for child care for teen mothers. Vouchers can be used for school attendance for teen mothers. Due to Federal WIN regulations, teen mothers under 18 years, who live with their families, cannot receive DPW voucher day care if their families are ineligible for AFDC.

"In Massachusetts day care centers are defined as those facilities caring for more than six children. A fmaily day care system is an organized group of family day care homes sponsored by the same agency which provides supervision, training and referral."

The report, How Does Your Community Grow, defines available day care as follows:

Center-based care - provided in a facility that serves more than six children on a regular basis.
Family Day Care - provided for no more than six children in an individual's home.
Family day care systems - a group of family day care homes administered by a private agency.

The Office for Children has established the Affordability Day Care Scholarship Program, and has earmarked $350,000 for day care affordability for FY 87 and FY 88.

OFC has designed and will pilot a scholarship fund to "accurately document how high costs of day care affects working families, and to help parents pay day care costs."

Through a lottery system, 150 income eligible families will be awarded day care scholarships for one year. The lottery is being conducted through six of OFC's Child Care Resource and Referral Programs.

Families who earn between 71% and 100% of the state's adjusted income - from $17,304 to $24,696 for a family of three - will be eligible to participate. The Program accepts matching funds from private sources. The Office for Children has guidelines for applicants to follow. The six areas targeted are: Greater Lawrence, the North Shore, and Tri-City; Greater Worcester and Southern Worcester County; Greater New Bedford, Cape Cod and the Islands; Greater Lowell, Metro-West, and Central Middlesex; Hampden County, and Cambridge, Somerville, Boston, Newton and environs.

The Final Report of the Governor's Day Care Partnership Initiative states, "The role of public schools in providing child care is also expanding as a result of current trends in education. A new nation-wide interest in early childhood education, stimulated by research demonstrating long-term benefits for participating students, is reflected in the state's new early childhood incentive grant program, created as part of the Massachusetts Public School Improvement Act of 1985, Chapter 188." These early childhood grants are made available to local school districts for planning and operating new programs designed to meet the needs of children ages three to six years. The law requires that 75% of the funds be targeted to low-income sites. The first grants, mostly for planning, were made to 140 school districts in June, 1986. A total of $10.2 million was available during the 1986-1987 fiscal year. Collaboratives have been formed between school officials and child care experts to initiate new full and part time programs for children of working parents in many communities. The Early Childhood Grant program is administered by the Department of Education, which requires participating school districts to form advisory councils with day care representation from the local Child Care Resource and Referral agency.

Day Care Services for Teen Parents

The Final Report of the Governor's Day Care Partnership Initiative states, "The growing problem of adolescent parenthood also suggests a role for the

schools in child care. High schools have begun to respond by opening day care centers for the infants and todlers of their students in communities such as Cambridge, Worcester and Taunton." In May, 1986, the Advisory Committee established a set of policy recommendations requesting that local coalitions be developed, along with a comprehensible service model including special day care centers for the children of teen parents.

"The costs of operating day care programs for teen parents are now being shared by local and state government." In FY 87, DSS subsidized specialized day care for about 120 children of teen parents in high school and community settings in Boston, Cambridge, Chelsea, Fall River, Marlborough, Somerville, Taunton and Worcester. "Hundreds of other teen parents are receiving state subsidized care in day care programs with state contracts or through the Employment and Training CHOICES (ET) program." The Youth Initiatives part of the ET budget for FY 87 expanded services to pregnant and parenting teenagers, with a request by the Governor for $2 million in new funds for this population. The language allowed teen parents who do not receive AFDC or General Relief (GR) for themselves, but who do receive it for their children, to participate in ET programs. All ET participants are eligible for vouchers for day care.

According to studies conducted with the Young Parents Initiative programs of DSS in 1985, 42% of the participants in the programs at intake, or who delivered while in the program, had no source of day care. The availability of day care influences many young mother's ability to succeed with their education, vocational training, and employment goals. Two-thirds of those who had help with child care were able to attend school or obtain jobs.

The average costs of child care ranges between $3,000 to $6,000 and up to $10,000 annually. The average pre-school rate for state-contracted care in Massachusetts is $13.50 a day. According to a chart in the Final Report, source-Dana Friedman, "Corporate Financial Assistance for Child Care," weekly child care costs in Boston for 1985 consisted of:

	care in home	family day care	center day care
child under 2 years	$260-$340	$45-$160	$90-$150
Child 2-5 years		$40-$160	$75-$110

The Final Report also contains an example of the sliding fee scale used for families receiving state subsidized day care in FY 87. The source cited is the Department of Social Services. Income breakdown and weekly fee, for a family of 2 or 3 members using preschool or family day care is as follows:

Annual Family Income	Weekly Fee Charged
$10,000	$13
16,000	23
22,000	53.50
25,000	61

Recommendations

For FY 88, the Child Care Coalition has determined six major areas of need: availability of basic DSS slots for income eligible families; wages and training dollars for child care workers; affordability of care for families; true cost reimbursements for providers; and rate increases for supportive services care. The Coalition requests that DSS, OFC and EOHS expand their budgets in these areas.

In April, 1986 the Governor's Day Care Advisory Committee formed a Task Force on Day Care for Teen Parents. Recommendations by the Task Force, as stated by the Alliance for Young Families are as follows:

1. Locally Based Comprehensive Services: Services for teen parents and their children should be planned locally through a coalition effort.

2. A Comprehensive Service Model for this population which addresses the various needs of teen parents and their children should be promoted.

3. Day Care for this population should have special components and characteristics which include:
   parenting education/skill development
   opportunities for role modeling
   staff who are also trained in adolescent development
   transportation
   hours which can accommodate school hours/year
   case management or a staff who can provide assistance with other service needs, act as liaison with other providers
   health and nutrition information for parent and child
   staff trained to deal with infants who are at risk due to low birthweight and premature births
   special services for infants/toddlers
   outreach and follow-up services for teens

4. Positive, active leadership from the Governor's Office, Executive Office of Human Services and the Department of Education is requested.

5. Specialized day care programs for teen parents should be developed. Models to be promoted should include:
   school-based day care
   community-based day care services -center or family day care
   a combination of both

6. Day care services, whether school or community based, should at least meet OFC licensing regulations, and have appropriate quality standards.

7. Additional subsidized day care is needed, with priority given to refugee and adolescent parents.

8. The responsibility for funding day care services for teen parents should be a shared responsibility.

9. A representative group should be established to determine necessary funding mechanisms for day care services for teen parents and their children.

10. Day care services for the children of teen parents should be coordinated with early intervention programs.

11. Use of School Building Assistance Bureau funds for renovation and capital outlay of public schools property for child care purposes should be promoted.

12. Final recommendations and future efforts on this topic should be coordinated with the Working Group on Teen Pregnancy currently sponsored by the Governor's Office on Women's Issues.

13. The task force should continue to meet to refine the recommendations and assist with any planning or implementation activities.

The manual, How Does Your Community Grow? Planting Seeds for Quality Day Care, presents the principles and practical steps from work with the Citizen Involvement for Day Care Quality Project, housed with the Office for Children. The Project provided intensive training and assistance to volunteers on how to assess quality day care services and advocate for employer involvement in child care. The committee reviewed and recommended revisions in DSS's standards for quality in state-funded day care centers. The Project computerized statewide day care information. The manual describes a component of the Project to present an overview. Key principles and specific tips that can be applied in other contexts are stated in the following areas:

*Volunteer recruitment and training
*Skill-building
*Designing of written materials
*Conflict resolution
*Designing and running successful meetings
*Coalition building

The programs and services listed below are described in the Programs and Services Section on Massachusetts, and are listed by Health Service Area. The following are the names and addresses of the programs containing a day care component:

Health Service Area I

#21. Northhampton, Sojourn
142 Main Street 01060
413-586-6807

#24. Pittsfield, Teen Parent Program
Stearns School
Lebanon Ave.
413-443-2530

Health Service Area II

#8. Worcester, Children's Friend Society
School Age Mothers, SAM
21 Cedar Street 01609
Carol Epstein 753-5425
Louise Caswell

#18. Teen CARE Program, Worcester
Burncoat Senior High School
179 Burncoat Street 01606
Betsy Wertheimer, 799-3322
(See description in programs)

Health Service Area III

#14. Lawrence, New Beginning Program
Lawrence Public Schools
58 Lawrence Street 01840
Susan O'Neill, 686-7701

Health Service Area IV

#21. Boston, English High School
CSAPP, Inc.
Comprehensive School-Age Parenting Program, Inc.
77 Avenue Louis Pasteur 02115
Bette Bohlke-O'Gara, 738-9034

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Legislative and Budgetary Initiatives

In FY87, the Department of Social Services requested $65,488,660 for day care services, including Cost of Living increase, $.9 million for 200 new basic slots, 40 targeted for teens; $1.2 million for 200 new supportive services slots; $1 million for 350 continuity of care/ extended voucher slots; and wage increases. For FY87, House 1 budgeted $63,716,638 for day care services, including Cost of Living increase; 250 new basic slots for teen parents, public housing residents and high demand areas; 350 continuity of care/extended vouchers; 200 supportive services slots; and wage increases.

For FY87, the Department of Public Welfare requested $23,487, 443, including COLA, $2.5 million for 900 new slots and $1.5 million for transportation, in voucher day care services. These day care slots allow participants in ET programs to have subsidized day care. House 1 requested $21,525,152, including COLA and 1,000 new vouchers.

The Child Care Coalition, in it's FY87-88 budget recommendations, noted that there has been significant increases in voucher day care, serving participants in ET CHOICES programs. The advocates recommended funding for 600 new placements for income eligible families, 250 new placements for the children of teen parents, and $650,000 for affordability funds to establish a tuition assistance fund for eligible families, and a statewide survey to be conducted to document the dimension of the need for subsidies. The Coalition recommended day care funding and improvements as needed in the following areas: more state-supported placements for children in care; assistance for parents who cannot afford costs of child care; state reimbursement to providers for actual cost of care; training for staff and family day care providers; better pay and benefits for child care workers and family day care providers.

The DSS budget for FY88 for day care services expansion is $79,550,000 plus language for 850 new slots, 620 basic, 215 for teen parents, and 25 for the New Chardon St. Temporary Home for Women. The Department of Public Welfare budget for voucher day care for FY88 is $30,231,716.

The Department of Social Services has recently released the RFP for the 215 teen parent day care slots funded in the FY88 budget. The date for the beginning of the contracts is April 19, 1988.

The Alliance for Young Families has done a breakdown of the distribution of the 215 slots by DSS regions:

Region 1	37	Region 4	22
Region 2	32	Region 5	45
Region 3	45	Region 6	34

The House 1 recommendation for FY89 includes annualization of new services begun in FY88, and targets funds for 100 new teen parent slots. The Alliance for Young Families recommends 500 new slots.

Several day care initiatives have been proposed in the 1988 legislative session. Some focus on day care in institutions of higher education. Representative Fiero has proposed legislation for day care and transportation for student mothers, with a community plan for needs assessments.

PROGRAMS AND SERVICES: CHILD CARE
MASSACHUSETTS

Representative Saundra Graham and Senator John Olver, have filed House 4452, An Act to Provide Child Care Linkage. This act would require most developers who build or renovate more than 50,000 square feet of space to construct an on- or near-site child care center, or to pay an in-lieu child care fee into a special fund. It would also require the state to include child care facilities in new buildings, wherever feasible.

Developers choosing to build a new center would have to provide space equal to 2% of the new facility free of charge to a licensed non-profit child care provider. Those choosing the fee would contribute monies to a Child Care Development Fund each year for 10 years. The funds would establish a grants program to help provider serve more children through subsidies and capital improvements. Low- and moderate-income development employees would be given top priority for the new services created.

PROGRAMS AND SERVICES: JOB TRAINING & EMPLOYMENT

Introduction

Nearly 8.5 million Americans are looking for work. More than 75% of the workforce for the year 2,000 is already working today. The workplace is changing. In the next 15 years, between five and fifteen million manufacturing jobs in America will be restructured," and an equal number of jobs in the service sector will become obsolete. The new jobs that are coming on line are likely to require higher skills from American workers.

Jobs are increasingly requiring strengthened basic skills. According to the Children's Defense Fund, a formal education is now a prerequisite for almost any kind of job. "From 1900 to 1981, the number of jobs in America's white collar and service sectors rose from one-sixth to more than one-half of all jobs. The proportion of agricultural, blue collar, and manufacturing jobs has dropped substantially, while the educational requirements for getting and holding jobs has increased." According to the Division of Employment Security, two-thirds of employment growth has been in industries, many of which require workers with relatively high levels of education, and higher levels of literacy skills.

In 1950, there were 17 workers for each retiree; by 2,000 there will be only 5 workers for each retiree.

According to the report of the National Research Council, Risking the Future, "Approximately 7.8 million teenagers ages 16-19 reported that they were in the civilian labor force in July, 1985. Approximately 6.3 million were employed either part or full time, despite the fact that many of them were also enrolled in school."

The employment gap between black and white men ages 16-19 increased extensively. In 1954, 42% of white 16-19 year olds, and 38% of black 16-19 year olds were employed. In 1984, 56% of white youths and 27% of black, or one in four, youths were employed. In 1985, 48% of white teens were employed, as compared to 25% of black teens.[494]

Introduction

In 1985, 1.5 million teenagers were unemployed," either because they could not find work, or were not looking for a job." According to the National Research Council, "Unemployment was significantly greater among black teenagers than among white teenagers, 41% compared with 16%," and it was slightly higher for males of both races than for females." Minority youths are three times as likely to be unemployed if they are dropouts. The following chart gives employment status by race, sex, and age, for 1984-1985. Data on Hispanic employment and unemployment status are not published by age category.

TABLE 2-4 Employment Status by Race, Sex, and Age, 1984–1985
(seasonally adjusted, in thousands)

	1984	1985
Whites ages 16–19		
Civilian labor force	6,952	6,852
participation rate	57.5	57.7
Employed	5,893	5,733
Employment-population ratio	48.7	48.3
Unemployed	1,059	1,119
Unemployment rate	15.2	16.3
Men	15.2	17.5
Women	14.3	15.0
Blacks ages 16–19		
Civilian labor force	849	915
participation rate	39.4	42.4
Employed	490	537
Employment-population ratio	22.7	24.9
Unemployed	359	378
Unemployment rate	42.3	41.3
Men	42.3	43.3
Women	42.2	39.0

NOTE: Hispanic breakdowns not available for the years presented.

SOURCE: U.S. Department of Labor, "The Employment Situation: July 1985," *News*, U.S. Department of Labor 85-304, August 2, 1985.

Source: Risking the Future: Adolescent Sexuality, "Pregnancy, and Childbearing. National Research Council, Washington, D.C." 1987

Introduction

Nearly 14 million American young people are growing up in poverty today. Many have no one in their family that is working and will provide a role model. Often these youth face little or no opportunities for work experience for themselves. Joblessness during youth has a long term harmful effect on success in the job market later in life.

Teenage unemployment rates averaged around 17% over the period of 1977-1980, but rose to over 23% in 1983. For minority teens, the unemployment rate in 1983 was over 36%. 495

"While out of wedlock teenage pregnancy rates are increasing, during the rest of this decade and into the 1990's, women will account for two-thirds of the labor force growth." 496

According to Joy Dryfoos, the Children's Defense Fund, and others, pregnant and parenting teens face severe obstacles when trying to get jobs. They lack human capital to bring to the labor force; they lack educational credentials, have little prior work experience; have few marketable skills; and have parenting responsibilities. These factors, coupled with the fact that many teen parents have their children as single parents, create further barriers to teen parents becoming participants in the labor force, and even further barriers to participating in the labor force in elevated, higher paying jobs.

Since 1970, the number and percent of all children and teens with working mothers has risen steadily, from 45% in 1960 to 62% in 1985. Many of those single mothers seeking work are, or have been teen parents. Teen mothers are less likely to find stable and remunerative employment than those who delay parenthood. Teen mothers may have more children during their younger years, and may have them at closer intervals. Because they accumulate less work experience, have lower hourly wages... because they have completed less schooling and consequently have lower status occupations, "they experience serious negative effects in their labor market position, which contributes to their lack of satisfaction with their jobs." 497

Teenagers who have children when 18 or younger earn about two-thirds as much as those who wait until they are 20 or older.

A high school dropout is two and one-half times more likely to be unemployed than a high school graduate.[498] A recent estimate of the total lifetime earnings loss by dropouts who would have graduated from high school in 1981 alone, was $228 billion, with an approximate loss of $68.4 billion in tax revenue.

Pregnant and parenting teenagers are among the disadvantaged populations most likely to drop out of school. Teen mothers who drop out earn about one-half during their lifetime, if they earn at all, of the income of those who remain in school, and delay parenthood.

The Job Training Partnership Act (JTPA)

The JTPA is the major federal legislation authorizing employment training for youths and adults. JTPA, which replaced the Comprehensive Employment and Training Act (CETA), began program operations in October, 1983. The annual budget for this program has been around $3.6 million.

JTPA has two stated purposes, according to Dr. Polit's report:

1. to prepare youths and unskilled adults for entry into the labor market

2. to train economically disadvantaged individuals who face serious barriers to employment

According to Dr. Polit, "The legislation is based on the premise that training programs should meet the needs of employers for skilled workers, while simultaneously addressing the training needs of the unskilled and chronically unemployed."

The responsibility for policy formation and administration of JTPA funds is handled at the state and local levels. Each state is awarded funds based on a formula that considers a state's population and unemployment rates. The state, in turn, distributes training funds to local government entities called Service Delivery Areas (SDAs). SDAs can be cities, counties, or multi-county areas. Within each state, the governor and staff develop a framework for complying with the JTPA legislation, and in many cases also develop state-wide policy guidelines. The SDAs are responsible for program implementation and for allocation of JTPA funds to local program operators who provide employment training.

Under JTPA, private sector involvement is mandated at both the state and local levels. At the state level, a State Job Training Coordinating Council (SJTCC) plans and forms policies, and one-third of it's members must be from the private sector. At the local level, each SDA works with a Private Industry Council (PIC). The Act requires that the majority of a PIC's membership be from private industry. Each PIC is responsible, in partnership with the local elected officials, for planning, implementing, and monitoring employment and training activities that reflect the SDAs eligible population, and employment opportunitis in the private sector.

JTPA consists of five parts or "titles". Title II has relevance to teen parents. It provides for a year-round training program for disadvantaged adults and youth, Title IIA, and a summer youth program, Title IIB.

JTPA

In each state, JTPA monies are divided into several categories:

78% of the state's allocation is earmarked for training programs for adults and youth

40% of this training money is designated for youth programs

therefore, about one-third of a state's JTPA allocation must be spent on employment and training programs for youth, ages 21 and under

in addition to the "78% funds", 8% of a state's allocation is designated for use in educational programs to improve basic skills

3% is for programs for older individuals

6% is for "incentive grants" to reward SDAs for performance in some area

5% is for state administration

JTPA emphasizes training to public assistance recipients, which can take several forms. The Act requires those receiving AFDC who are required to register for employment-related services, to be served in proportion to their incidence in their local communities. The Act states that one measure of program performance is a reduction in rates of welfare dependency.

JTPA funds can be used for a number of employment/training activities. The most common uses of Title IIA training funds are for the following:

- occupational classroom skills training
- on the job training
- work experience
- other classroom training including basic education and job-readiness preparation

JTPA program performance must be measured by explicit performance standards. Each SDA is responsible for meeting certain standards, such as the percent of program participants entering employment after training, in order to be eligible for funding. Therefore the SDA is motivated to award contracts to program operators that can perform well according to pre-designated performance criteria.

SDAs have the option of providing "needs-based payments" to participants, which are small weekly stipends given to economically disadvantaged participants to offset the costs associated with being in training, such as lunch and car fare. Each SDA can spend no more than 15% of total

expenditures on such non-training costs as needs-based payments and supportive services. The majority of SDAs have entered into unfunded agreements with other agencies for the provision of participant supports. One SDA in Massachusetts has unfunded agreements with the Department of Public Welfare and Social Services for the provision of child care services.

Certain parts of the Act can facilitate the use of JTPA funds for the teen parent population. Some of these include:

1. Young parents are a targeted group as unskilled youth, and economically disadvantaged youth facing barriers to eomployment.

2. Teen parents can qualify for Title IIA and Title IIB monies. They can also qualify under the 8% funds for educational programs to improve basic skills.

3. Performance standards are adjusted to reflect the barriers faced by certain populations in the labor market. There are various levels of standards depending on certain traits. Adjustments are not made for teen parents, but do reflect some of the characteristics of teen parents. SDAs can request a negotiated performance standard adjustment that exceeds the normal adjustment.

4. PICs are more aware of the needs of young parents and more receptive to addressing those needs.

5. Programs serving teen parents in employment-related components can offer PICs resources that other agencies might not have available.

6. Teen parent programs are often comprehensive in approach, which is likely to increase the likelihood that program participants will follow through in their program participation.

7. PICs have in some cases experienced funding cuts because of their inability to meet their goals in serving disadvantaged youth. By offering services to young parents, program operators can help their PIC achieve their goals.

Some of the barriers to using JTPA funds for teen parents are;

* Even with adjustments in performance criteria, there are still multiple problems for teen parents: lack of basic educational skills, high rates of absenteeism, child care, welfare bureaucracy, housing, transportation.

* Many teen parents may experience difficulties in meeting the entrance eligibility criteria for JTPA programs in terms of basic skills levels; programs often screen out applicants who have lower than a seventh grade reading level.

* The funding available for support services, especially for child care, may make this program inaccessible for teens.

* Training programs may be short and inflexible, and it may be difficult for teen parents with other demands to complete the program.

* The kind of training that is usually provided to young women under JTPA is frequently in clerical areas, where entry-level wages are low and inadequate for single heads of households.

JTPA Performance Standards

For youth, there are three performance standards for which SDAs are held accountable:

1. percent of participants entering employment at the end of the training period

2. percent of participants with a positive termination, that is, entering unsubsidized employment, entering another skilled program, returning to full-time school, etc.

3. the cost of service per positive termination, that is, total program costs divided by the number of positive terminations

Sources: Denise F. Polit, Ph.D. "Building Self-Sufficiency: A Guide to Vocational and Employment Services for Teenage Parents", Humanalysis, Inc. MO, 1986.
"Implementing the Job Training Partnership Act", National Governors' Association Information Exchange.

The Executive Office of Economic Affairs administers a range of programs for employment and training. Those with whom pregnant and parenting teens may be involved are the Office of Training and Employment Policy (OTEP), the Bay State Skills Corporation (BSSC), and the Division of Employment Security (DES). OTEP administers the JTPA in Massachusetts, and is a major source of employment training for teens. As of January 1, 1988, DES became the Department of Employment and Training, and will assume responsibility for OTEP.

As stated in the description of the JTPA program, teens have difficulty in meeting criteria and performance standards under JTPA, experience difficulties with child care and transportation, have problems in maintaining participation in the programs, and other difficulties.

The Bay State Skills Corporation is funded by the state, and forms partnerships with industry and educational institutions through state and private industry matches. BSSC puts out RFP;s four times a year, and funds programs with colleges, vocation education schools, and training institutions.

Pregnant and Parenting Teen Grant

OTEP entered into an agreement with the Department of Public Welfare in 1986, to "develop an initiative to reduce the potential for long-term welfare dependency among AFDC pregnant and parenting teens. Comprehensive services are to be provided which develop the skills needed for long-term income self-sufficiency."

Advisory groups were established to facilitate coordination of necessary support services with education, training and placement services.

OTEP issued a policy directive to outline the planning requirements, allocations, and timetable for the $1,400,000 Pregnant and Parenting Teen Grant.

Programs include:

Basic education toward a high school diploma or GED.
Parenting and life skills education.

Vocational exploration.
Work readiness education.
Job-specific skills training.
Placement services for part and full time employment.

Performance goals include:

A 65% positive outcome rate.
30% of these (20%) overall) shall include placement in full or part time employment.
50% of positive outcomes were to be achieved by June 30, 1987; the balance no later than December 31, 1987.

Participating SDAs had to prepare a plan for serving 16-19 year old pregnant and parenting teens who were receiving AFDC and General Relief. Plans were submitted to Ms. Sondra Stein, Associate Planner for OTEP.

As part of the joint Youth Initiative, two further goals were identified:

1. to establish a local collaborative planning and problem solving process involving the employment and training system, educational system, and health and social service delivery system for a comprehensive approach to building self-sufficiency for pregnant and parenting teens

2. to implement a comprehensive strategy through innovative, effective programs that provide an integrated array of services to pregnant and parenting teens

The grant program outline grouped teenagers' needs into five general categories:

basic survival
academic skills
vocational services
independent living skills
support services

The outline states that there should be coordination among agencies, at the regional, policy development level and facilitated at the service delivery levels, through strong local networks and good case management practices.

The following are considered positive outcomes:

* entry into part or full time employment
* return to school
* attainment of basic education and pre-employment or work maturity competencies
* attainment of a GED or high school diploma
* entry into skills training
* successful completion of skills training
* entry into advanced skills training or higher education

Eligibility requirements include:

- 16-19 year old pregnant teens, part of a household that qualifies for AFDC/GR, and eligible for ET
- 16-19 year old mothers, part of a household that qualifies for AFDC/GR, and eligible for ET
- 16-19 year old teen fathers, part of a household that qualifies for AFDC/GR, and eligible for ET

According to the outline from OTEP, "teens eligible for participation through other grants must meet the eligibility guidelines of the program from which funding is requested. SDAs may choose to apply Title IIA and 8% income eligibility windows in order to expand eligibility to all teen parents within the SDA."

Program strategies incorporate a comprehensive model following a three-track system:

1. Educational; basic skills, parenting and other survival skills, pre-employment and work maturity skills

2. Employment-related; vocational training and placement in part or full-time employment

3. The third track is a more extensive client services track that begins with an aggressive outreach strategy and includes an equally aggressive long-term post placement follow-up strategy.

Funds may be used for the following activities:

Outreach	Job Development
Assessment	Job Placement
Education in youth competency areas	Case Management, Advocacy, Referral
Vocational skills training	Follow-up

Supportive Services: Important supportive services are child care, transportation, access to health care, access to safe, affordable housing, and personal, academic, and vocational counseling.

Performance Standards:

* the average cost per participant shall not exceed $3,100.
* the positive outcomes rate shall be no less than 65%, and shall include: return to school; attainment of basic

education and pre-employment or work maturity competencies; attainment of a GED or high school diploma; entry into skills training; successful completion of skills training; entry into part or full time employment; entry into advanced skills training or higher education.

* the entered employment rate shall be no less than 30% of the 65% positive outcome rate, as measured by 100% retention 30 days after placement

* all participants had to be enrolled by July 1, 1987

The plan contained components on reporting requirements, monitoring, evaluation, and budgets.

The following SDAs were allocated funds as stated for FY87:

Berkshire	$0 (refused funds)	Boston	$218,900
Bristol	$ 93,400	Brockton	$ 64,500
Franklin/ Hampshire	57,400	Hampden	155,400
Lower Merrimack	85,400	Metro North	109,200
Metro South/ West	60,000	New Bedford	179,200
North Middlesex	60,000	North Worcester	60,700
South Coastal	75,600	Southern Essex	64,400
South Worcester	115,900		

ET CHOICES

The Department of Public Welfare FY88 Budget Narrative outlined three key sets of initiatives: improved alternatives to poverty and benefits for clients; improved service delivery for clients through case management; improved management and savings.

The Employment and Training (ET) program is a major focus for expansion in the Department. However, ET and other programs are experiencing federal WIN cutbacks. The Work Incentive Program (WIN) is a program to help AFDC recipients become self-supporting wage earners by providing a wide range of employment, training, and social services for registrants. Federal law requires that persons 16 or older who are receiving or applying for AFDC must register for WIN unless they are exemp - full time students and mothers or other females caring for a child under 6 years of age when the father or other male relative in the house registered with WIN.

The ET Youth Choices program is designed to prevent poverty and long-term welfare dependency by addressing two of it's principal causes: teen pregnancy and dropping out of school. Funding currently serves approximately 4200 youths.

Services focus on three different youth populations, including pregnant and parenting teens, with educational and vocational services for teen fathers as well as mothers. Services target junior high school students with drop out prevention programs, and older out of school youth, with a major effort to develop a Youth Community Service Corps. The program is designed to help teen parents complete high school and acquire the necessary skills to find employment.

Teens under 16 years of age are exempt from ET programs. Absent parents and teen parents who receive AFDC or GR for their infants are eligible for ET.

Sites for ET for parenting teens are Sojourn, with Northhampton providing GED and pre-vocational services and Greenfield providing counseling and referral services; Employment Connections in Chelsea, servicing 25 adolscents with GED, Skills training and ESL - funding - $50,513; Crittenton Hastings House, servicing 60 youths, with care management, child care on site, and a subcontract with Jobs for Your for GED educational services, funding - $168,171; CARE, servicing 50 youth with ESL, GED, pre-vocational training, and child care on-site-funding - $179,772; Cardinal Cushing Center, Boston - funding - $28,340; Chicopee Area Health Resources - funding - $149,235.

Recipients may participate in basic education skills training and job referral, career counseling, and support work programs. All ET participants are eligible for day care benefits for the period of time they participate in programs, as well as for 12 months immediately following placement. ET graduates who are placed in jobs without employer health insurance receive coverage in an HMO for up to 12 months after being placed in a job. Day care is provided primarily through the voucher day care program, which provides a subsidy to licensed child care providers. Problems here are that many participants cannot find day care to insufficiency of providers, and the fact that providers do not always accept vouchers, as they do not provide payments at market rates. Teen parents also have very young children and infants.

Federal cutbacks in JTPA have been substantial. Between one-third and one-half of participants in such programs have been welfare recipients and participate in JTPA programs as their ET activity. Title IIA funds were cut by almost $4 million from FY86 to FY87, and further cuts are expected.

In FY86 the ET budget was $28.2 million, of which $17 million was from federal sources and $11 million from the state. The FY87 budget included $16.5 million in state money, added to only $8 million in federal funds due to cuts in the WIN program. ET had a $24.5 million budget in FY87, as compared to $28.2 in FY86. FY88 budgets attempt to correct cutbacks, with figures at $29 million. The budget contains language including monies for pregnant and parenting - $1.07 million in annualized funds.

According to a report from the Urban Institute, "family planning clinics serve significant numbers of sexually active teens, mostly low-income or marginally above poverty, all of whom obviously have some motivation to contracept effectively. They miss approximately half of the relevant female teen population. They miss virtually all of the relevant teen male population, and efforts of these clinics to involve teen males have met with little success."[499]

Even among those teens who do use the services of family planning clinics, 40-60% of the teenage clients never return for the periodic check-ups that are crucial for safe, effective use of contraceptives. In 1980, Johns Hopkins Hospital studied why teens selected a particular family planning clinic. The most important reasons given were confidentiality, that the staff cared about the teens, sites were located near homes, and clinics were recommended by friends.

While there is no certain way of determining how many teenagers are sexually active in Massachusetts, studies by the Department of Public Health state that the number of family planning visits by teenagers across the state to clinics gives some idea, and can be used as a determinant.[500]

In 1980, 13,597 youth under 18 visited family planning clinics; 14,231 18 and 19 year olds visited the clinics. In 1983, 15,791 youth under 18 years visited the clinics, and in that same year, 16,923 18 and 19 year olds did. In 1984, participants in the MAPPS study were asked about their use of contraceptives. Of those responding, 8.7% stated that they always use contraceptives; 28.6% stated that they sometimes use them; and 62.8% stated that they never use contraceptives.

According to the report from the Department of Public Welfare, "Increasing Enrollment in Project Good Health", a report to the Commissioner, in 1985, "in 1984, teenagers represented 36% of all family planning clients for services, or 31,071. The unmet need for services to teenagers was stated as 66,559. The Department of Public Health, MAPPS study indicates that 14,707 of these were less than 18 years old, and 16,364 were 18 and 19 years old. These figures do not include visits to private physicians, or to hospital gynecological clinics. Figures must be added to family planning visits of those teenagers who become pregnant, experience a miscarriage, stillbirth, abortion, or birth, when determining those who are sexually active.

According to a report from the Department of Public Welfare, cited above, "while use of family planning agencies by adolescents is growing, the proportion of sexually active teenagers that receive family planning services is still very small. It has been estimated that more than 190,000 adolescent girls, and a similar number of boys, are sexually active. Although this statistic indicates that three times as many teenagers are utilizing such services as in 1975, it still means that roughly nine out of ten sexually active teens are not benefiting from family planning services."

Family Planning Services

Family planning services can be provided with federal funds under four different programs, Social Services Block Grant; the

Maternal and Child Health Block Grant; Medicaid (Title XIX of the Social Security Act), and Title X of the Public Health Services Act. Title X has provided the majority of the funding over the past decade; however, use of Medicaid funding has increased.

About 10% of family planning clinics require parental consent or notification as a condition of teenagers receiving services.

Some goals of family planning services, as stated by the Massachusetts Association of Family Planning Project Directors, is to provide comprehensive family planning services to all low-income females and males, and teenagers. Services are linked to other health and needed services. The purposes of the clinics are to provide support for consistent follow-up, use and application of information and knowledge, counseling, and specialized services for the unique needs of teenagers; to reduce low birthweight births; pregnancy testing in order to access teens to early prenatal care.

According to a statement from ABCD, Mary Russell, Director, there are currently in Massachusetts, approximately 65,000 teens whose family planning needs are unmet, and who need subsidized family planning. These teens are at risk of poor pregnancy outcomes and repeat, unplanned pregnancies.

In 1984, 85,180 men and women were provided family planning services. The clients were from the Title X target populations:

Target Population	% of clients	No. Served	Unmet Need
Below 150% Poverty	75%	63,885	144,015
Below 200% Poverty	95%	80,921	217,799
Teens	36%	31,071	66,559

For FY88, DSS requested $2 million in additional funding for family planning services. For FY88, the Mass. Family Planning Association recommended that a $2 million Initiative to Prevent Unintended Pregnancy be included in the Human Services Budget.

Family planning clinics are strategically located to serve low income women throughout Massachusetts. All clinics accept Medicaid and have sliding fee scales and provide free care when necessary.

The following pages contain a list of the Dept. of Social Service Family Planning Contracts for FY88, and a map of Title X Family Planning Sites.

The Mass. Directory of Services contain lists and addresses, and services of Planned Parenthood League of Massachusetts sites.

DEPARTMENT OF SOCIAL SERVICES FAMILY PLANNING CONTRACTS- FY88

TOTAL FY88 FUNDING: $2.5 million.

Abington

Health Care of Southeastern Massachusetts
728 Brockton Ave.
Abington, Ma. 02351

Beverly

Healthquarters
19 Broadway St.
Beverly, Ma. 01915

Boston

Action for Boston Community Development
178 Tremont St.
Boston, Ma. 02111

Brighton

Crittendon Hastings House
10 Perthshire Rd.
Brighton, Ma. 02135

Cambridge

Cambridge Economic Opportunity
11 Inman St.
Cambridge, Ma. 02139

Chelsea

General Hospital Corporation
Chelsea Memorial Health Center
100 Bellingham St.
Chelsea, Ma. 02150

Fall River

Citizens for Citizens
264 Griffen St.
Fall River, Ma. 02720

Fitchburg

Montachusetts Opportunity Council
732 Main St.
Fitchburg, Ma. 01420

Lowell

Healthworks, Inc.
125 Perry St.
Lowell, Ma. 01851

Northampton

Family Planning Council of Western Mass.
16 Center St.
Northampton, Ma. 01060

Roxbury

New England Hospital
55 Dimock St.
Roxbury, Ma. 02119

Somerville

Somerville Hospital
230 Highland Ave.
Somerville, Ma. 02143

Worcester

Health Awareness of Central Mass.
71 Elm St.
Worcester, Ma. 01609

MASSACHUSETTS TITLE X
FAMILY PLANNING SITES

Young Parents Initiative

According to the Department of Social Services, adolescents and their families can enter the Department through one of three routes: voluntary requests for services, as victims of serious abuse and neglect, and through court referrals through the Children in Need of Services (CHINS) judicial process.

The Department of Social Services provides a range of services and resources for adolescents and their families based on an evaluation of individual needs. According to the Department, "resources for these youth must reflect the varied needs of adolescents and their families." The Department has stated that it recognizes the need for a full range of resources to be made available to meet the needs of youths and families.

Currently, adolescents account for 20% of all consumers in DSS, 38% of all children in DSS, 44% of all consumers in placements, and 50% of all children in placements. Approximately 18,000 adolescents are serviced each month. In 1986, about 14,000 teens were served in their own homes, nearly 3,000 foster care placements, and about 1,150 are in group care placements.

In 1982, the State Legislature voted to provide new monies to the Department to fund ten new programs for pregnant and parenting teens. The Young Parents Initiative provided one million dollars annually for these programs, beginning in January, 1983. Many other programs have been funded since this time, with several focusing on preventive services.

A total of 887 pregnant and parenting teens enrolled in the ten programs during the first year and a half of operation - 294 in the first six months, and 593 during the subsequent year. In March, 1985, the Department of Social Services published a report, "An Evaluation of Programs Funded by the Young Parents Initiative." The following list gives the distribution of the 887 enrollees, by program locations and program names:

No. of Enrollees	Name of Program
267	Aswalos House/Boston YWCA
41	Attleboro Youth and Family Services
30	Concilio
116	El Centro
48	Hampshire County Teen Pregnancy-Parenting Network
67	Health Information and Referral Services
111	Healthworks
30	Hull Teen Clinic
90	New Bedford Area Coalition
87	North Shore Children's Hospital

A description of each program, and statistical data and information are presented in the evaluation report. Brief descriptions are stated under each regional service area of the Department. The following information is taken from the evaluation report.

* the average length of the 289 consumers' enrollment in the program was 32 weeks; one-third were still enrolled after a year of service

* an average of 3.3 hours of service were provided to the consumers each week they participated in the programs

* two-thirds of the time was spent on direct services, such as counseling, support groups, health care, academic and employment programs; one-third consisted of indirect services, such as referrals, collaboration, travel and tracking consumers

* consumers were provided with an average of 114 hours of services during their enrollment

The 289 consumers who were followed in the study enrolled in the programs between January and June, 1983. They were residents of one of 44 Massachusetts cities and towns at the time of intake, and the average age was 17.8 years. Of those enrollees who were followed, 53% were parents, 41% were pregnant, and the rest were both pregnant and parenting. Three-fourths of the enrollees had only one pregnancy, or were experiencing their first pregnancy when they began participating in the programs. The average age at the time of the first delivery was 16.9 years.

Other relevant information about the characteristics of the population at intake, taken from the evaluation report:

* 42% were white, 30% were black, 25% were hispanic; remainder were Portuguese, Cape Verdean and Jamaican

* 18% were born outside the continental U.S.; 5% spoke languages other than English

* 9 out of 10 were single at intake; one-half lived with parents

* 6 out of 10 had dropped out of school; 11% had completed school

* 4 out of 10 had been employed in the past; 12% were employed when they enrolled in the programs

* 60% were continuing their relationship with the baby's father

* 9% were married at intake; 3% were separated or divorced

* 49% had used some form of birth control in the past; 16% were using a method immediately prior to conceiving their most recent or current pregnancy

* 83% stated that they had not planned to become pregnant, but only 17% had used a method of birth control to prevent pregnancy

* 53% were supported entirely by welfare at enrollment; 2% by a combination of welfare and employment; 32% by their parents, husbands, boyfriends, or their own employment; 13% by other means

Young Parents Initiative

The programs selected for funding by the Department were judged to be models of three types of programs:

1. School-based: These programs are sited in public high schools, in order to identify, provide outreach to, and counsel pregnant and parenting students. School personnel are given training and support by these programs in order to enhance their understanding of the needs of this population.
   Funded programs: Attleboro Youth and Family Services
   Aswalos House/Boston YWCA
   Health Information and Referral Services

2. Community-based: Programs are located in neighborhood agencies and health clinics in order to serve young people who are pregnant and parenting in local communities. Services may include counseling, GED and tutoring programs, employment training, and support groups.
   Funded programs: Aswalos House
   Concilio
   El Centro del Cardinale
   Hampshire County Teen Pregnancy-Parenting Network
   Healthworks
   Health Information and Referral Services
   North Shore Children's Hospital

3. Family Resource: Programs that provide temporary foster care for pregnant and parenting young mothers and their children.
   Funded programs: Hampshire County Teen Pregnancy-Parenting Network
   North Shore Children's Hospital

The following is a brief description of each program as contained in the DSS evaluation report. Programs are presented according to the Regional Areas serviced by the Department of Social Services. Evaluation information and outcome data are stated at the end of the program summaries.

Programs that were not included in this evaluation, or have been newly contracted as Young Parents Initiative programs, are listed at the end of each DSS region.

For FY88, DSS Young Parents Initiatives programs were appropriated $3.2 million- $2.7 for community-based programs, and $.5 million for school-based programs.

DEPARTMENT OF SOCIAL SERVICES REGIONS AND AREAS

REGION I

Area	1	Pittsfield
	2	Northampton
	3	Holyoke
	4	Springfield
	5	Westfield

REGION II

Area	6	Fitchburg
	7	Gardner
	8	Blackstone Valley
	9	South Central
	10	Worcester

REGION III

Area	11	Lowell
	12	Lawrence
	13	Haverhill
	14	Cape Ann
	15	Danvers/Salem
	16	Lynn/Chelsea
	17	Eastern Middlesex
	18	Tri-City

REGION IV

Area	19	Concord
	20	Mystic Valley
	21	Beaverbrook
	22	Cambridge
	23	Marlboro
	24	Framingham
	25	Newton
	26	Norwood
	27	Quincy
	28	Coastal

REGION V

Area	29	Attleboro
	30	Brockton
	31	Plymouth
	32	Taunton
	33	Fall River
	34	New Bedford
	35	Cape and Islands

REGION VI

Area	36	Boston State
	37	Boston/Brookline
	38	Boston Univ.
	39	Tufts-Bay Cove
	40	Harbor

DSS Region I

Hampshire County Teen Pregnancy-Parenting Network, Northampton

Community-based, Family Resource

The program represents a coalition of four agencies: Sojourn, Family Planning Council of Western Mass., Children's and Family Service of Hampshire County, Learning Intervention Family Team at the University of Mass., Amherst. Programs provide outreach, counseling, GED classes, vocational guidance. Services are coordinated by a social worker at Sojourn, and services are provided by an outreach worker, vocational counselor, and three additional social workers, one at each site.

Between January and June, 1983, 19 consumers joined the program. Eighteen of these were followed up and monitored. Between June, 1983 and June, 1984, an additional 29 young women were enrolled.

At intake, the average age of the 18 consumers who were followed-up was 18 years. Fourteen of the consumers, or 50%, were seen for counseling in their own homes; 12 were seen in program offices.

Requested services for which there were no referral resources were in the areas of welfare, housing, day care, emergency assistance, and employment.

Outcome data for the program participants included: none of the consumers experienced a subsequent pregnancy while in the programs; 9 out of 11 who had not completed school participated in an academic program - 4 in GED classes, 3 in traditional schools, 1 in an alternative school, 1 in college; 7 sought employment, 6 worked while in the program; 6 attended a job training program; half had child care, the rest had none; 7 were supported by husband's, boyfriend's, parents' or their own employment, 2 by welfare and employment, 9 by welfare.

DSS Young Parent Contracts, Region I

The following programs have been funded through the Department of Social Services. These programs were not included in the Department's evaluation report.

Name of Program	Amount Funded	Program Description #
Springfield: Our Lady of Providence Children's Center Brightside	$18,245 $16,015	Health Service Area (HSA) I, #27
YWCA P.A.G.E.	$25,042 $100,333	HSA I, #28
Children's Aid and Family Services 8 Trumbull Rd. Northampton, Ma.		HSA I, #19
Sojourn, Inc. 142 Main St. Northampton, Ma. 01060		HSA I, #21
Berkshire Center for Families and Children 472 W. St. Pittsfield, Ma.		HSA I

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DSS Young Parents Contracts, Region II

The following programs have been funded through the Department of Social Services. These programs were not included in the Department's evaluation report. Program descriptions may be found in Section

Name of Program	Amount Funded	Program Description #
Worcester: Catholic Charities	$21,661 10,619 23,081	HSA II, #7
Worcester: Children's Friend Society	$38,145	HSA II, #8
Family Planning Council of Central Mass.	$18,132	HSA II, #10
Worcester Children's Friend Society	$42,091	HSA II, #8
Catholic Charitable Bureau	$29,476	HSA II, #7
Fitchburg: Montachusetts Opportunity Council	$27,819	HSA II, #2
Community Counseling of Blackstone Valley 101 Main St. Hopedale, Ma. 01747		HSA II, #
Health Awareness of Central Mass. 71 Elm St. Worcester, Ma. 01609		HSA II, #12

DSS Region III

Healthworks, Lowell

Community-Based

The program is located in the Healthworks' offices in Lowell, Lawrence, and Haverhill. Family planning and pregnancy testing services are available to the public from these offices.

The programs provide counseling, advocacy, and referral services for young women throughout their prenatal period, and following delivery. Services are coordinated by a social worker based in the Lowell office, and additional outreach workers and social workers are located in Haverhill and Lawrence.

During the period from January to May, 1983, 15 consumers were enrolled and 14 were followed up. Another 96 consumers joined the program from June, 1983 to June, 1984.

At intake, the average age of the first 14 consumers was 17 years.

Requests for which there were no referral services were in the areas of day care and employment.

Some of the outcome data included:

* 7 girls used birth control pills, 1 boyfriend used condoms, 3 used nothing

* 5 who had not graduated from high school were enrolled in an academic program, including 1 who graduated and 1 who went on to college after graduating

* 1 looked for employment, 3 worked while in the program, 2 participated in job training classes

* 1 of 11 mothers had access to day care, her mother, 10 had no source of child care

* 3 of the 13 consumers whose income source was known were supported by their parents', husband's, or their own employment, 3 by a combination of employment and welfare, 7 by welfare alone, 3 more than at intake

North Shore Children's Hospital, Peabody

Community-based, Family Resource

The program is located in the North Shore Child Development Center in Peabody, and is sponsored by the Children's Hospital. The program offers counseling and vocational guidance. Coordination is carried out by a social worker at the Child Development Center. Services are provided by three additional case managers, located at Project RAP, the North Shore Community Mental Health Center, and North Shore Child Development Center.

From March to June, 1983, 28 consumers were enrolled, and an additional 59 consumers joined the program between June, 1983 and June, 1984.

At intake, the average age of the first 28 consumers was 17.9 years.

Seven requested help finding housing; no referral resource was available.

Some of the outcome data included:

* 14 used birth control pills, 10 used nothing, those who used pills did so for 86% of their non-pregnant months, 9 used them for the entire time,. 4 of those who did not use birth control said they disliked available methods, 1 did not intend to have a sexual relationship, 1 was afraid of possible side effects

* 3 had an additional pregnancy while in the program, 1 planned, the others not planned

* 1 had an abortion

* 7 of the 22 who had not completed school were enrolled in an academic program during enrollment-3 in traditional schools, 2 in GED programs, 2 in tutoring programs, 2 graduated while in the programs

* 9 worked while enrolled, 1 had a full time job,7 attended job training programs

* 6 of the 23 had access to some form of day care, 16 had no source of child care

* 4 of the 28 were supported entirely by parents', husband's, or their own employment, 19 received both AFDC and income from employment, 5 received only welfare at follow-up, 17 less than at intake

The following programs have been funded through the Department of Social Services. These programs were not included in the evaluation report.

Name of Program	Amount Funded	Program Description #
Lowell-Lawrence; Healthworks	$163,579 $108,326	HSA III, # 12, 19
Catholic Family Services 55 Lynn Shore Dr. Lynn, Ma. 01902		HSA III, # 10
No. Shore Children's Hospital 40 Washington St. Peabody, Ma.		HSA III, #14
No. Shore Catholic Charities 37 Margin St. Peabody, Ma. 01960		HSA III, #13

DSS Region IV

Health Information and Referral Services (HIRS), Marlboro

School and Community-based

The program is located in the Marlboro and Algonquin Regional High Schools, and at the agency's family planning clinic in Marlboro. Referrals are also sought at three other high schools.

The program provides teacher training and classroom presentations for students. The program offers counseling, GED classes, vocational guidance for pregnant and parenting teens. Services are coordinated by a social worker, and additional staff also include a GED instructor, a nurse, and two social workers-counselors.

From February to June, 1983, 27 consumers enrolled in the program, 26 were followed-up.

At intake, the average age of the 26 consumers was 17.8 years.

Some of the outcome data includes:

* 16 of the 20 who had not graduated from high school prior to intake attended academic classes while in the program - 8 were enrolled in traditional schools, 6 in GED, 2 in alternative schools, 4 did not attend at all

* 4 graduated from high school, 2 others obtained GED diplomas while in the program

* 14 looked for employment, 13 found jobs, 5 worked full time, 4 attended job training programs

* 12 of 23 mothers had access to day care- 9 used babysitters, usually their mothers, 3 used family day care, 9 had no access to day care

* 12 were supported by parents', husband's, boyfriend's or their own employment at follow-up, 13 by welfare alone, 6 more than at intake, 1 worked and collected AFDC

* 10 of 15 pregnant at intake delivered full-term babies whom they kept, 2 gave up babies for adoption, 1 had an abortion, 1 had a miscarriage, 1 delivered a stillborn infant

* 18 of the 25 who delivered used a method of birth control: 11 used pills, 5 a diaphragm, 1 an IUD

Requests for services for which there were no referral resources were in the areas of Medicaid-financed prenatal care, housing, emergency assistance, academic education, day care, employment, and legal services.

DSS Region IV

Concilio, Cambridge

Community-based

The program was established by a Cambridge counseling agency which serves the city's Spanish-speaking population. The program provides counseling for Hispanic women who are pregnant or parenting. The agency works with other local agencies to identify and provide outreach and counseling to consumers living in the community. An administrator and one counselor provide program services.

During March and June, 1983, 9 consumers were enrolled and 3 were followed-up. An additional 21 consumers joined the program between June, 1983, and June, 1984.

The average age of the consumers, the first 8, was 19.6 years.

Requests for services for which there were no referral resources were in the areas of housing, academic education, day care and employment.

* none experienced a subsequent pregnancy

* 2 of 6 who had not completed high school attended academic classes while in the program, 1 completed high school and went on to college, 1 attended ESL classes sponsored by the program

* 4 looked for employment, all 4 found jobs, 1 attended job training

* 4 of 7 mothers had a source of day care, 3 had none

* 4 were supported entirely by their boyfriend's, husband's, or their own employment, 4 by welfare alone, 1 more than at intake

Hull Teen Clinic, Hull and Quincy

Community-based

The program is located in the Hull Health Clinic and the Quincy Family Planning Clinic and is staffed by a half-time social worker. The program provides outreach and counseling to parents and pregnant adolescents.

During March and June, 1983, 9 consumers enrolled, and an additional 21 enrolled between June, 1983 and June, 1984.

At intake, the average age of the first 9 consumers was 17.8 years.

Requests for services for which there were no referral resources were in the areas of housing, academic education, day care and employment.

* those who used contraceptives did so for an average of 86% of their non-pregnant program months, 2 used birth control for the entire time

* none experienced a subsequent pregnancy

* 6 of the 8 who had not completed school enrolled in academic programs- 3 in traditional schools, 3 in GED programs

* 1 graduated while in the program, 1 received a GED diploma

* 2 looked for employment, 2 worked during enrollment

* 3 had access to day care, 4 had none, 1 child was in foster care

* 3 were supported entirely by husband's, parents' or their own employment, 4 by both AFDC and employment, 2 by welfare alone, 2 less than at intake

DSS Young Parents Contracts, Region IV

The following programs have been funded through the Department of Social Services. These programs were not included in the Department's evaluation report. Program descriptions are found in the listings section.

Name of Program	Program Description #
Cambridge Family and Children's Services 99 Bishop Richard Allen Dr. Cambridge, Ma. 02139	HSA IV, #38
Health Information and Referral Box 160 Marlboro, Ma. 01752	HSA IV, #72
Quincy Teen Mother's Program 18 Spear St. Bethany Congregational Church	HSA IV, #76
Catholic Charities of Cambridge/Somerville 270 Washington St. Somerville, Ma. 02145	HSA IV, #
Greater Framingham Mental Health 88 Lincoln St. Framingham, Ma. 01701	HSA IV, #64

DSS Region V

Attleboro Youth and Family Services, Attleboro

School-based

The program supplements a community-based program that has been funded by DSS Area 29 since July, 1982. The new component established an in-school counseling service for pregnant and parenting students at Attleboro High School. Referrals are also sought from school personnel in 3 surrounding towns: North Attleboro, Mansfield, Norton. Program services are provided by a social worker/coordinator, a group worker, and a nurse.

During February and June, 1983, 18 consumers were enrolled. From June, 1983 to June, 1984, an additional 23 consumers joined the program.

At intake, the average age of the first 18 consumers was 17 years.

Requests for services for which there were no referral resources are in the areas of Medicaid-Financed Prenatal Care, welfare, housing, and Emergency Assistance.

Some of the outcome data included:

* none experienced a subsequent pregnancy

* 12 of the 17 who had not completed school at intake were enrolled in an academic program during enrollment-11 in traditional school, 1 in GED, 4 graduated from high school while in the program

* 6 looked for employment, 8 worked while enrolled, 2 had full time jobs

* 12 had access to day care, 3 had no day care resource

* 14 were supported entirely by husband's, boyfriend's, parents', or their own employment, 4 by welfare, 2 less than at intake

New Bedford Area Coalition, New Bedford

Community-based

The program is the result of a coalition between New Bedford Child and Family Services, the New Bedford Office for Children, and the Greater New Bedford Health Clinic. The program provides counseling and health care, as well as an alternative high school for consumers. It is coordinated by an administrator and case manager at Child and Family Services, and is staffed by additional counselors and teachers at other sites.

During February and June, 1983, 28 consumers were enrolled and 27 were followed-up. From June, 1983 to June, 1984, an additional 62 consumers had joined the program.

At intake, the average age of the first 37 consumers was 16.8 years.

Requests for services for which there were no resource referrals were in the areas of Medicaid-Financed Prenatal Care, welfare, housing, day care, employment and Emergency Assistance.

New Bedford Area Coalition

Some of the outcome data included:

* 14 of the 25 mothers used birth control pills, 6 used nothing, 7 of those who used birth control did so for all of the non-pregnant months they were in the program

* consumers who used contraceptives did so for 73% of their non-pregnant program months, 3 disliked the available methods, 1 was afraid of possible side effects

* 4 had an additional pregnancy while in the program, 3 of these had abortions, 1 planned to keep the child, 3 of the 4 subsequent pregnancies were unplanned

* 15 of the 25 who had not graduated from school attended academic classes while enrolled, including 1 who graduated and 3 who obtained their GED

* 7 looked for work, all obtained employment, 4 in full-time jobs, 3 in part-time jobs, 3 attended job training programs

* 14 of the mothers had access to day care, half used a center sponsored by the program that is located in its alternative school

* 10 were supported entirely by their parents', husband's, boy-friend's, or their own employment at follow-up, 4 by a combination of welfare and employment, 3 by welfare alone, 11 less than at intake

DSS Young Parents Contracts, Region V

The followint programs have been funded through the Department of Social Services. These programs were not included in the Department's evaluation report, or were added since the evaluation. Program descriptions are found in the listings section.

Name of Program	Program Description #
Healthcare of Southeastern Ma. 728 Brockton Ave. Abington, Ma. 02351	HSA V, #1
Cape Cod Mental Health Assoc. 175 W. Main St. Hyannis, Ma. 02601	HSA V, #6
New Bedford Child and Family Services 141 Page St. New Bedford, Ma. 02740	HSA V, #18
Plymouth Community Nurse Assoc. 22 Summer St. Plymouth, Ma. 02360	HSA Vi, #21

DSS Region VI, Aswalos House/Boston YWCA, Roxbury

School-based and Community-based

The program is the result of a coalition of 5 organizations: Aswalos House, YWCA on Clarendon St., Harvard St. Health Clinic and Jeremiah Burke and Dorchester High Schools. Services are provided at all sites. Services include counseling, health care, GED classes, tutoring, job training. The in-school staff provides the teacher training about adolescent pregnancy and parenthood. The program is coordinated by an administrator at Aswalos House, additional staff include a counselor at each site, a vocational trainer, and 2 outreach workers. During March to June, 1983, 91 consumers were enrolled, and from June, 1983 to June, 1984, an additional 176 were enrolled.

The average age of the first 91 consumers at intake was 18.6 years.

Requests for services for which there was no referral resource was in the following areas: welfare, housing, academic education, day care, and employment.

Some of the outcome data include:

* 64 of the 88 mothers used a method of birth control while in the program, 6 tried a second method, 52 used birth control pills, 8 an IUD, 4 tried a diaphragm, 24 used nothing

* those who used contraceptives did so for 93% of their non-pregnant program time, 48 used a method for the entire time

* 5 had a subsequent pregnancy- 2 planned to keep the babies, 1 had a miscarriage, 2 terminated prior to making a decision, none had planned to conceive

* 78 who had not completed school attended an academic program during enrollment- 44 attended traditional schools, including

* 12 who graduated and 3 who went on to college, 33 attended GED programs, including 4 who obtained GED diplomas

* 46 looked for employment, 37 worked while in the program- 11 at full time jobs, 16 part-time, 34 were in job training programs

* 51 had access to day care- 22 relied on family members, 9 used babysitters outside their homes, 13 used day care centers, 7 used family day care, 32 had no source of day care

* 29 were supported entirely by their parents', boyfriend's, husband's, or their own employment at follow-up, 24 by a combination of employment and welfare, 36 by welfare alone, 21 fewer than at intake

DSS Region VI

El Centro Del Cardinale, Boston

Community-based

The program is sponsored by the Cardinal Cushing Center for Spanish-speaking people, an agency that serves Boston's Hispanic population. The young parent's program is called Projecto Amor, and is a continuation of a nationally-funded demonstration project, Project Redirection (see national programs for a full description and research evaluation). Participants are reached and counseled in their own homes by women who live in the community and are themselves parents. Social workers and teachers provide counseling, GED, and tutorial programs, and supervise the community women.

Projecto Amor enrolled 50 consumers was 16 years.

Requests for services for which there were no referral resources were in the areas of housing, day care,. legal services, employment, Medicaid-Financed Prenatal Care.

Outcome data included:

* 15 of the 22 who were pregnant at intake kept their babies, 1 had an abortion, 1 delivered a still-born infant, 1 had a miscarriage 4 terminated services prior to delivery

* 36 of the mothers used a method of birth control while in the program, 2 tried a second method as well, 33 used birth control pills, 2 an IUD, 1 young woman's partner used condoms, 7 did not use birth control at all

* consumers used contraceptives for 84% of their non-pregnant program time, 23 used birth control for the entire time

* 4 had an additional pregnancy while in the program, 1 had 2 pregnancies, of the 6 subsequent pregnancies, 1 ended in abortion and 1 in miscarriage

* 3 planned to keep their babies, 1 terminated services before delivery, of the 5 who conceived again, all said the pregnancy was unplanned

* 40 of the 46 consumers who had not completed high school at intake attended an academic program during enrollment- 10 attended traditional schools, 28 enrolled in GED classes, 2 in alternative schools, 4 received GED diplomas, 6 did not attend school at all

* 13 sought employment, 5 worked while in the program, 5 attended a job training program

* 31 had access to day care- 27 relied on family members, 2 used paid babysitters, 2 used day care centers, 9 had no day care

* 8 were supported entirely by their parents', husband's, boyfriend's, or their own employment at follow-up, 4 by a combination of employment and welfare, 38 by welfare alone, 7 more than at intake

DSS Young Parents Contracts, Region 6

The following programs have been funded through the Department of Social Services. These programs were not included in the Department's evaluation report. Program descriptions may be found in Section

Name of Program	Amount Funded	Program Description #
Boston; YWCA	$147,475 172,191 30,165	HSA IV, #55
Boston Childrens Service Association	$48,369 71,393	HSA IV, #5
Bridge, Inc.	$39,376	HSA IV, #10
Crittendon Hastings House	$23,815	HSA IV, #18
Catholic Charitable Bureau	$107,057	HSA IV, #14
Whittier St. Health Center	$27,477	HSA IV, #63
Children's Hospital	$46,801	HSA IV, #15
Cardinal Cushing Center	$103,997	HSA IV, #13
Comprehensive School-Age Parenting Program	$52,861	HSA IV, #21

Dare, Inc., Boston

Trustees of Health and Hospitals
818 Harrison Ave.
Boston, Ma. 02118

Children's Hospital Corp.
Martha Eliot Health Center

Roxbury Children's Services
22 Elm Hill Ave.
Dorchester, Ma. 02121

PROGRAMS AND SERVICES: SOCIAL SERVICES
MASS. DEPT. OF SOCIAL SERVICES

According to the Department of Social Services' evaluation report, "the programs were highly successful in helping consumers to achieve specific program goals: school enrollment and completion, employment, consistent use of birth control, avoidance of subsequent pregnancies, and reduced welfare dependency." The following chart is a summary of the achievement of these goals:

	At Intake	At Follow-Up	%Change
School Enrollment	40%	74%	+34%
School Completion	11%	14%	+3%
Employment	12%	30%	+18%
Job Training	1%	21%	+20%
Use of Birth Control	45%	71%	+26%
Subsequent Pregnancies		7%	
Welfare Dependency	53%	46%	-7%

The report further states, "consumers who enrolled in programs that contained within them the services needed to achieve these goals (academic or GED classes, job training and education, and family planning services) were more likely to remain in school, obtain employment, and use birth control. Those who enrolled in programs that offered only counseling and referred consumers to other agencies for additional services, were less likely to do so." The report states that other factors associated with the ability to achieve goals were age, pregnancy, and school status, and income source at intake.

The following are general findings from the evaluation report, which also gives specific findings by category of program component.

General Findings;

- Young parents who participated in programs that include academic classes, family planning services, and job training and counseling, are more likely to achieve program goals than those who do not. Young mothers appear to make substantial gains in these areas when the services they need are located within the program setting.

- Programs that were school-based, or that ran alternative high schools or GED classes were the most successful in enrolling young parents who had dropped out prior to intake.

- Programs that offer consumers academic classes that are located within the sponsoring agency have the highest rates of success in retaining youth in school to completion.

Transition to Independent Living: Program initiatives that give youth practical tools to become self-sufficient, and to gain more control over their lives. The concept of defining independent living becomes an integral part of service plans for adolescents. Specific skills to be developed are individualized to meet the needs of each youth. Programs provide counseling and/or an out of home placement for older adolescents to help them acquire the skills, supports and confidence to live on their own. Programs are funded in conjunction with Chapters 689 and 707. Each program includes 4-5 apartments in one building, with live-in supervision. Each young parent has own apartment and receives training and counseling in parenting skills and household management. Programs are linked to community educational or job training programs. Programs are for 6-12 months residential participation with an additional 6 months after care/follow-up period. Three program models:

Staffed Apartment Model: Provides 24 hour per day resident supervision in a program-provided apartment with intensive instruction and support.

Supervised Apartment Model: Provides an apartment plus instruction, support and supervision by non-resident staff.

Transition Planning Model: Provides support to adolescents who are about to leave their family or foster family.

For those whose primary or preferred language is other than English, or who have impaired sensory, manual, or speaking skills, bilingual counselors, interpreters, or other aids to communication are provided.

A curriculum is presented which covers, at a minimum:
- nutrition and cooking
- financial planning/money management
- health and hygiene
- sexuality
- community resources and services
- consumer information
- residential needs: apartments, leases, tenants rights and responsibilities
- improvement of interpersonal skills

Program offers a curriculum on employment related issues for adolescents which covers, at a minimum:
- vocational planning
- job hunting skills
- work maturity skills
- daily employment responsibilities

The Department of Social Services has a Transition to Independent Living Program Prototype, which states a thorough description of the programs. For FY87, $250,000 was appropriated for support services for 4 new transition to independent living programs in Fitchburg, Springfield, Boston, and Cape Cod. For FY88, monies were appropriated to fund 10 new TIL programs.

PROGRAMS AND SERVICES: SOCIAL SERVICES
DEPT. OF SOCIAL SERVICES

In 1984, the Statewide Adolescent Issues Task Force was established by Commissioner Marie Matava, Dept. of Social Services. A goal of the Task Force, according to a report issued, was to"define vital issues affecting adolescent services and to further identify programs and policy directions for the Dept. of Social Services." The purpose of the report, titled, Adolescent Issues Summary Report: Adolescent Task Force Report and Recommendations, December, 1985, was:

1. To study unmet needs and to create a continuum of resources more responsive to the unique needs of adolescents and families.

2. To provide Regional and Area office staff with the support necessary to deliver quality services.

Many of the recommendations from the report were implemented, and a number of initiatives were undertaken by the Department of Social Services.

One of the recommendations from the report, implemented as administrative supports on behalf of adolescent services, was the establishment of a Central Office Adolescent Advisory Workgroup, and the expansion of comprehensive training on adolescent issues for social work and supervisory staff. "In order to develop stronger networks for adolescent resources, the Department increased collaboration at the Central, Regional and Area office level, by working with other state and community based agencies to jointly plan and fund adolescent services." The Department has also drafted an Adolescent Services brochure for the public.

The Department recognizes that it must continue to support and expand the continuum of resources for adolescents. The initial Task Force report stated, "many of the practiced and traditional approaches... are not effective with adolescents who are facing normal adolescent separation issues and /or experiencing devastating failure and possible lack of support from their biological families. Programs with hands-on experiences appear to influence adolescents positively and are result-oriented. These programs promote self-sufficiency and give adolescents a sense of accomplishment and control over their lives." The report states that skills encouraging youth to assume responsibility for themselves as they move toward adulthood, are very important in programming.

The report emphasizes the need for a more aggressive pursuit of preventive services such as the expansion of tracking, mediation, peer support groups and outward bound type day programs. The Task Force also recommended as part of a preventive initiative, increased support for services to Emergency shelters, through developing interagency planning and funding to extend services in areas of mental health, health care, substance abuse, education and employment training. The Task Force strongly supports the Department's goal to increase resources, for adolescents and families.

Teenagers are experiencing serious problems in emotional and mental health aspects of their lives. A discussion of this area is in the introductory section of this report.

According to the authors of Student Pregnancy: How Schools Can Combat Student Pregnancy, "the suicide rate for teen mothers is higher than that for other teens. The number of teen mothers who attempt suicide is seven times the rate of young teen women without children."

Many pregnant and parenting teens have been the victim of sexual and physical abuse, family violence and instability, alcoholism, and drug abuse, and other problem-behaviors and experiences.

Some studies state that teen parents are more likely to abuse their children because of restricted social networks. However, other studies state that, when environmental and socioeconomic factors are controlled for, teen parents are neither more nor less likely to abuse their children than are other parents. Teen mothers are often faced with multiple stressors involving child-rearing, living in poverty, isolation from support networks, having a poorly developed self-identity, and raising children who are less likely to be healthy. Teen fathers often are burdened with finding work, quitting school, and supporting their child or children. Teen parents often have few resources available to them to talk about their feelings, frustrations, and anxieties. Some studies indicate that "adolescent parents are at high risk of having mental health problems."[501]

The Children's Policy Information Project has published an issue brief, "Providing Mental Health Services for Children and Youth". In it, the authors state that children and youth are seriously underserved in the provision of mental health services, and in their accessibility and availability. Also, many services that are provided are not geared to the specific needs and problem-behaviors of children and teenagers.

The National Association of Counties has stated, "local programs should emphasize community-based treatemnt - treatment in the context of the family and community - rather than institutionalization. Mental illness among children and adolescents is often linked to family problems such as child abuse and neglect, an alcoholic and substance abusing parent, death of a family member or divorce. Because of the pivotal role of the family in a child's development, the child and the family should be involved in treatment."

Mental health services are currently under serious financial and funding contraints. The Children's Policy Information Project states, "unfortunately, child mental health services represents a "pay now or pay later" dilemma. The problems of children with mental health problems, for the most part, get worse without treatment. Unserved children become the disturbed adult population, requiring more expensive mental health, welfare, or correction services."

In 1984, the Mass. Dept. of Mental Health reported that the state had 1.9 million children, adolescents, and youth under the age of 22 years. Estimates of the prevalence of mental illness in this age group ranges from 8% to 15%. Using the conservative figure of 8%, Massachusetts has approximately 152,000 children and youth who may be experiencing emotional problems and who are in need of mental health services. Within the total youth population, approximately 2.5%, or 48,000 children and adolescents may be severely emotionally disturbed.

A spokesperson for the Department of Mental Health stated that there have been several pregnant teenagers who have attempted suicide. The resources to service and treat teenagers, especially on an inpatient basis, are limited.

Outpatient services are available to pregnant teenagers, especially for these teenagers, and all teenagers, who are in need, or are experiencing a crisis. The Department of Mental Health provides $1.5 million to support an array of consultative services to students, teachers, and guidance staff in approximately 90 school districts throughout the Commonwealth. These do not include services provided by DMH staff assigned to Community Mental Health Centers and Partnership Clinics.

The Department collaborated with other agencies on a Teen Suicide Prevention Task Force, which has since issued a report.

The following lists describe funded school-based consultation and/or treatment programs, through the Department of Mental Health.

Some information taken from letter from Joan Mikula, Assistant Commissioner, Child-Adolescent Services.

DEPARTMENT OF MENTAL HEALTH - SCHOOL-BASED INITIATIVES FY'88

DMH AREA	SCHOOL DISTRICT	TARGET GROUP	PROJECT DESCRIPTION	FUNDING INFORMATION
Berkshire	Pittsfield LEAs, open to entire community	Berkshire Area emotionally disturbed adolescents	Integrated day treatment program including individual group and/or family therapy vocational training	$ 91,443
	LEAs - N. Berkshire County	Emotionally disturbed adolescents	Case consultation and training in DMH issues, especially suicide prevention	25,000
	All Central and Southern Berkshire County LEAs	Depressed and suicidal adolescents	Training school personnel to recognize and respond to the target group's needs	8,000
Holyoke-Chicopee	Holyoke-Chicopee, S. Hadley, Granby, Ludlow, Belchertown, and Southampton	Elementary Schools, High Schools, Middle School	On-site outreach counselling to schools, case consultation/ evaluation	85,288
Springfield	Springfield, Longmeadow, Hampden, Wilbraham	Students of private and public schools, teachers and personnel	School consultation	25,280
No. Central	Winchendon Elementary School	Children referred to guidance counselors	Clinical supervision is provided to guidance counselors on difficult cases	
	Headstart programs in the Gardner and Barre areas.	Children referred to program identified as at-risk		
	Quabbin Regional High School	Adolescents experiencing difficulties in the school system referred to guidance counselors	Clinician co-leads a 12 week support group for adolescents experiencing difficulty in system, and with developmental issues related to adolescence. Case consultation also provided to guidance counselors.	

DEPARTMENT OF MENTAL HEALTH - SCHOOL-BASED INITIATIVES (CONT.)

DMH AREA	SCHOOL DISTRICT	TARGET GROUP	PROJECT DESCRIPTION	FUNDING INFORMATION
No. Central	Gardner High School	Adolescents referred to guidance counselors	Adolescents in school system are trained to provide peer support through ongoing peer counselor support groups that are held in the school. Group addresses issues such as teen-age suicide, drug and alcohol abuse as well as developmental issues related to adolescence. Monthly advisory meetings are attended by a clinician from North Central Human Services.	Funding provided by DMH Consultation & Education contract - $2,051 as well as state employees and other state agencies
So. Central	Dudley, Charlton, Shepard Hill Regional, North Brookfield, West Brookfield	Children identified as special needs kids who would also benefit from Mental Health services that guidance staff cannot handle	Evaluation; group and individual counseling; testing, and teacher consultation	Services jointly funded by local school and the use of DMH 5047 account class rate Area contract; funding for services provided in school approximate $20,000
Worcestesr	Worcester and surrounding towns	Multiple dimensions ranging from preventive services to direct student assessment	Various programs consisting of the following services: 1. Consultation & education contracts with 6 different schools in mental health and student related matters; 2. Regulatory group activity in areas of child study, transition and family dynamics; 3. Training through Hispanic, black and deaf services; 4. Case evaluation and psychological assessment requestsed	Approximately $30,000

DMH AREA	SCHOOL DISTRICT	TARGET GROUP	PROJECT DESCRIPTION	FUNDING INFORMATION
Worcester	Worcester	Behaviorally disordered adolescents within school system	5. In class proctoring for behavioral problem students, along with training and case review line teaching staff. Services provided by UMass psych program through Ph.D psychologist	$ 15,400
Blackstone Valley	14 school districts of catchment area	Two primary targeted problem areas: 1) childhood sexual abuse 2) adolescent suicide	1,700 hours of direct face-to-face service $48.60 per hour	82,619.99

DMH AREA	SCHOOL DISTRICT	TARGET GROUP	PROJECT DESCRIPTION	FUNDING INFORMATION
Lowell	8 School systems	Severe E.D. school age children & adolescents	After school day treatment program as alternative to residential placement	$ 300,629
	8 school systems	school age E.D. children and adolescents	School consultation/outreach services as part of an outpatient treatment contract with local agency	$ 40,000
Lawrence	4 school systems	E.D. adolescents age 13-19	Clinical support services for a day psycho-educational program	71,063
	Lawrence Public Schools	E.D. children & adolescents	Mental Health outpatient services provided in schools by therapists from mental health center.	Funded by third party reimbursement at the MHC $ amount not known
Lynn	Lynn, Swampscott, Nahant	School age E.D. children and adolescents	Individual and group therapy provided in school systems as part of mental health center outpatient services (includes Cambodian social worker)	Services provided by 5 DMH employees assigned to MHC plus third party reimbrusement ($183,450)
Tri-City	Malden, Medford and Everett	Severely disturbed adolescents	Therapeutic day activity program as alternative to residential placement	Program funded by DSS,DMH, DYS, LEAs. DMH funding $70,000 pays for most of clinical after school compponent
Cape Ann	Manchester, Gloucester and Beverly	School age children with emotional problems	School consultation (case and program) for teachers	$ 3,014
	Masconomet	Jr. High and high school adolescents	Outreach/peer education in school setting	$ 16,891 (50% funded contract w/local agency; 50% commun funding)
	Gloucester	2 latency age severely distrubed children	Project Adventure after school program	Joint funding DMH,DSS; LEA to provide transportation; projected DMH funding $4,000

Newton	School District	School Age Children	Therapeutic day activity program providing psychiatric counseling	$ 62,800

DEPARTMENT OF MENTAL HEALTH - SCHOOL-BASED INITIATIVES (CONT.)

DMH AREA	SCHOOL DISTRICT	TARGET GROUP	PROJECT DESCRIPTION	FUNDING INFORMATION
Fall River	Public Schools	Children 3-12 years	Consultation & Education; on-site counseling and parent group and outreach	
	Somerset	Adolescents 14-18 years	Consultation & education; teacher training	
	Westport	Children & adolescents ages 5-18	Outreach; consultation and on-site counseling	
	Freetown	Adolescents ages 14-18	Outreach; consultation and on-site counseling	
	Diocesese	Children and adolescents ages 5-13	Outreach and crisis counseling	
	Barnstable County Vocational School Agricultural School	Adolescents ages 14-18 Adolescents ages 14-18	Outreach; outside counseling Consultation & education	Total approximate funding $ 30,000
Boston	Agassiz and Tobin Elementary SChool	Kindergarten through eighth grade, ages 3-13 children & adolescents (500 individuals)	Individual and classroom consultation; individual and group therapy; leadership training; alcohol and drug abuse; education and family life education	$307,000

Background to Recommendations: Introduction

The following recommendations are presented for review and evaluation by state agencies, state officials, service providers, advocates, and all those who are working with, and interested in, pregnant and parenting teenagers. Each section of the report contains general and specific recommendations relative to certain areas, such as education, job training, health care, policy development, funding mechanisms, or service delivery networking. Persons studying this report are encouraged to review all areas that may be specific to their needs, and to determine recommendations that may be beneficial to their particular area of concern or need. Some persons may be interested in a specific type of service intervention; others may be interested in a certain element or component of a program for expansion. Some recommendations may be relevant to state, or federal, or community levels; others may be relevant to all levels. It is recognized that each recommendation should be viewed in the context of a community's identity and assessment of need. Community task forces and coalitions may wish to review recommendations to determine what is applicable and appropriate for their area, as part of a feasibility study or planning process. Of particular importance to all persons involved with pregnant and parenting teens is the section on factors influencing and determining behaviors in adolescents. These factors can be used as points of intervention and prevention strategies.

State and local officials, program planners, agencies and service providers are encouraged to review programs and recommendations for their relatedness to policies in Massachusetts that limit accessibility, usability, and eligibility for this population. Many groups, individuals and advocates are addressing some of these areas.

There have been, and are, reports in Massachusetts that address the issues and needs of pregnant and parenting teens, directly or indirectly. The reports have made substantial recommendations on a broad range of areas. Some of the recommendations of these reports have been implemented. Continued support for these recommendations is encouraged. Among the reports are "Uncertain Futures: Massachusetts Teen Parents and Their Children", a report of the statewide task force on pregnant and parenting teens, from the Alliance for Young Families, the Caucus of Women Legislators Task Force on Women and Poverty report on "Public Assistance Programs for Poor Women in Massachusetts", and the Task Force on the Prevention of Low Birthweight and Infant Mortality, from the Department of Public Health. Other reports containing areas of concern with this population are DPH MAPPS studies, and DSS Young Parents program evaluations.

When surveys of services and programs in the state were sent out to service providers and agencies, they were asked to make recommendations. These recommendations were analyzed and compiled, and are stated at the end of each Health Service Area in the listings section, and again in the Recommendations section. While percentages are given for each recommendation, these do not necessarily reflect that a particular need is a priority, or is more or less important than another need identified. The percentages stated represent the frequency with which the recommendation was stated. All areas may be as equally important to service providers, and to the teens they service. The recommendations come from those working with this population, and represent a wide diversification of need subject to change and variation, from housing and recreation, from transportation and day care to baby clothing, and from peer support groups to the need for support

systems to enable teens to return to school. Some areas identify gaps in services in a community; others reflect the community identity. Descrepancies between the perceptions of what state officials, agencies, service providers, and the teenagers view as needs must be identified and evaluated.

Some of the recommendations that follow, or are contained in the Health Service Areas, are needed "across the board". As teenagers as a group, and pregnant and parenting teenagers as a subgroup, are not homogeneous, careful attention must be paid to cultural, ethnic, race, educational, cognitive and psychological attainment, and other variables creating subgroups within this population. These factors must be incorporated into servicing models and needs assessments. Age differences and lifestyles, along with family dynamics, should be accommodated in program planning and development.

While intervention strategies may be effective and vitally important in alleviating some of the negative health, economic and educational consequences of teen pregnancy, they do not address the core issue: prevention.

Any program, service, or policy that encourages teens to stay in school, provides support and alternatives to encure their remaining in school, develops basic skills, meets the basic needs and promotes development of families and youth, develops life skills and learning experiences, provides work experience and training in job skills and employment, expands horizons and broadens life options and opportunities while providing the means and support to achieve goals, and gives teenagers the ability, motivation, learning and support to avoid negative behaviors - is prevention.

Research shows that early childbearing is often a product of low socio-economic status, and the lack of opportunity experienced by minority and poor young people. Therefore amelioration of some aspects of the social and economic environment, and a meeting of the basic needs for survival, should precede and accompany other interventions.

Educational and economic equity for young teen women is essential in all areas of educational, vocational education, job-training and career exploration, pre-employment and employment skills development, and in all areas of their socialization, and sex-role development. Young teen women should be assured of equal opportunities to participate fully in all sectors of society, and to develop and gain opportunities that are fulfilling and freely chosen. Equitable earnings and levels of achievement should be uniformly and equally available to all teen women and young women.

Effective prevention strategies should be embodied in a systematic network of support systems and services that promote positive youth and family development. Communities, with state and local assistance, should coordinate and integrate efforts and programs to address a variety of problems through a youth and family development framework. The focus would be on building the capacity of basic institutions to meet the basic needs of youth and families, and to equip young people and families with the necessary skills and life options to be able to participate in society.

Equity and quality of services should be ensured with respect to gender, cultural, and ethnic group identity.

Emphasis on youth and family development, with essential support systems and servicing networks in place, serves as primary prevention for children now, and in the future, including the children of teen parents.

GENERAL RECOMMENDATIONS

1. Effective prevention strategies should be embodied in a systematic network of support systems and services that promote positive youth and family development.

2. Broaden and enhance the life options and opportunities of every child and adolescent. These strategies would ensure: the basic needs of every person would be met; educational and economic equity for males and females; equity and equality of services with respect to gender, cultural, and ethnic group identity.

3. Family Life Education Programs should be mandated in all school systems in the Commonwealth, with linkages to community-based and other school-based programs.

4. Develop and implement comprehensive community plans to meet the needs of children, youth and families. The plan would identify resources, identify the target population, and include needs assessments. Comprehensive integrated servicing networks should be developed to meet the identified needs and gaps in services.

5. Short- and long-term research studies and evaluations should be conducted on program content, quality of service delivery, format, duration, the needs of the population serviced, location, and effectiveness.

Federal Level

1. Emphasis should be placed on programs and services to promote and enhance family development, child and youth development, especially for the poor and near-poor.

2. The federal government should formulate a policy of commitment to investment in children, youth, and families by promoting programs that enhance their lives, by promoting self-sufficiency and high school completion, by broadening and expanding life options and opportunities, and by improving the quality of their lives.

3. The federal government should ensure that the basic needs of every child, and every adult, individually and in families, are met with effectiveness and equality.

4. The federal government should support research studies which would help develop programs to involve families in their teens' lives with regard to decision-making, self-worth, pregnancy and early parenthood, teen sexuality and human development, and other important life decisions and planning.

5. The federal government should evaluate current and potential servicing models that have proven to be effective for both prevention and intervention strategies, to be identified and replicated. Emphasis should be placed on the crucial need for a balanced shift to prevention, while maintaining quality care in existing programs.

6. The federal government should review and evaluate all regulations, eligibility standards and requirements regarding the provision of benefits and services, in order to reduce and eliminate barriers to vitally needed care and services in public assistance, educational and vocational education and training, employment training and job skills development, social services and mental health services, and health and medical care.

State Level

1. Massachusetts has taken positive steps at the state level, including the Governor's Teenage Pregnancy Prevention Challenge Fund, the Coordinating Council on Adolescent Health Care, initiatives from the Executive Office of Human Services, and the efforts of state agencies discussed throughout this report. Expanded efforts and funding bases are vitally needed to develop and implement a coordinated, uniform policy and plan that is flexible for adapting to communities' identified needs.

2. The state should provide practical, technical, and funding assistance to support communities across the state in developing comprehensive community plans and needs identification, similar to the Action Plans developed by Chelsea, Lawrence, Fall River, and Springfield.

3. Increased funding and technical assistance are necessary to focus attention, awareness, and resources on prevention of teen pregnancy and associated behaviors, while maintaining the quality and continuity of care and effective service delivery for those teens who are pregnant and parenting.

4. The state should ensure that the basic needs of every child, youth, and adult, individually and in families, are met with effectiveness and equality as an effective prevention strategy.

State Level

5. The state should address the crucial needs and problems of families by developing and implementing programs focusing on family development and growth. Such programs include educational completion and continuation, early childhood education, alternative education, day care services, counseling, job training and skills development, health care, adequate housing, parenting education, in-home services, and other support services necessary to self-sufficiency and independence.

6. The state should identify and correct inequities and disparities in the provision of services, fragmentation and gaps in service delivery systems, insufficient quality of care, and inadequacy in the availability and accessibility of services and programs, to ensure that comprehensive, integrated servicing systems are available to children, youth and families. Funding inequities should be corrected, and potential improved use of funding mechanisms should be explored, such as grant programs, Aid to Families with Dependent Children, Early Periodic Diagnostic and Screening and Treatment Program, day care services, such as voucher day care, education and vocational education, and job training programs.

7. State agencies should act as liaisons and facilitators, and as part of referral networks for coordinated, efficient, and streamlined access to quality, effective servicing programs. At the state and local levels, public and contracted agencies should provide linkages with each other, and with other resources in the facilitation of needed services, information-sharing, and data collection.

The state should work with state and local agencies in identifying and eliminating barriers to care and access to services, by examining regulations and eligibility requirements in publicly funded programs.

8. The state should provide technical and funding assistance to programs, agencies, and service delivery systems in conducting evaluation studies and research projects. Areas of research should include:

effectiveness of servicing models
outcome data on populations to be serviced
profile and characteristics of population to be serviced
needs assessments
improved outreach, case management, follow-up, and monitoring
outcome data on effectiveness of specific services or service components
identifying problems causing attrition
identification of programs to be replicated and disseminated as effective models/intervention strategies

Research

Research areas, including servicing models, program outcomes, profiles and characteristics of populations to be serviced, effectiveness and feasibility studies, cost-effectiveness evaluations, are discussed throughout this report. The following are areas requiring research and evaluation studies.

1. Short and long-term research studies should be conducted on program content, quality of service delivery, format, duration, location and effectiveness.

2. Federal and state governments, and state agencies should fund, provide technical assistance to, replicate and disseminate research evaluations of, educational, health, social services, vocational education job training programs, pre-employment and employment skills acquisition services, and other servicing models. Aid should be provided to programs interested in developing these prototypes.

3. Exploratory research is needed on the impact of each option along a continuum of service delivery in meeting the needs, conflicts, and problems of children, youth and families, especially those relating to prevention of teen pregnancy, and servicing of pregnant and parenting teens.

4. Development of uniform data collection is needed so that program outcome and impact can be compared and disseminated for analysis of change, expansion and improvement. Data collection should include programs for male teenagers, the children of teens, those youth who are in services, and those who leave services.

5. Research is needed on the profile characteristics of at-risk teens, teens who are pregnant and parenting, the children of teens, and the family dynamics of at-risk teenagers.

6. While research is needed on teenagers who participate in services, it is also needed on those who drop out of, and leave services and programs, to determine reasons for leaving, and application to program models for improvement in accessing teens to programs, and maintaining them in services.

7. As pregnant and parenting teenagers often experience multiple problems such as family conflicts, substance abuse, suicide attempts, lack of adequate nutrition, housing and basic needs, and other such problems, research is needed on comprehensive service systems to meet multiproblem needs.

8. All agencies should conduct an internal assessment of the extent to which they are meeting the needs of their populations, and accurately report the extent of availability and utilization of these services.

Community Level

A model for comprehensive, multiservice and interdisciplinary community service delivery is enclosed with this report. The model consists of program types and models, with service elements and components taken from a review of programs across the country and information from the directors of these programs. The model can be used in determining types of models and interventions agencies and providers might want to review, components for expansion, and resources that can be tapped.

1. Communities should develop comprehensive community plans that contain needs assessments, community identity, population characteristics, available resources, potential resources, and other such factors. Those involved should include local agencies, providers, leaders and members of the community, advocates, and parents and youth.

2. Comprehensive community service plans should be developed and implemented after a community plan has been established that contains needs assessments, identification of existing resources and potential resources, funding sources and mechanisms, networks and collaboratives that are either in place, or to be formed, and other components.

3. Community plans should consider and reflect the varying moral, ethical, religious and ethnic and cultural beliefs and identity of community members, organizations and groups, institutions. Periodic reviews of available and potential resources, funding needs, population needs, changes in needs assessments, and other factors should be included in the plans.

4. A plan for implementation of the community plan should be developed, with timetables and designation of individual/agencies/organizations responsible for follow-up and implementation.

Services and Service Delivery

1. A comprehensive range of services is needed in every community, with a single point of entry, or case management for multiple points of entry, into a multiservice system, network and referral system. If comprehensive services are not feasible, integration and coordination of services is essential.

2. Agencies should actively identify gaps in services, duplication of services, and inadequacy of services by type and location, by servicing components, and by methods of improving networking, coordination, consolidation, and integration.

3. Case management, outreach and coordination, and follow-up and monitoring should be adequately funded.

4. Case management should be provided to every teenager and family to ensure that they receive the services needed, as early as they are needed, and for as long as they are needed.

Services and Service Delivery

5. Major emphasis should be placed on developing primary prevention and intervention strategies, such as family, child and youth development, educational and occupational enhancement, early childhood programs, school and community programs, and supportive services through transitional periods.

6. Programs should incorporate components such as life planning skills, self-esteem building, decision-making and communication, realistic goal-setting with practical support to achieve goals, job search and career exploration.

7. Four categories have been identified as problem areas in service delivery:

lack of affordability
lack of accessibility
lack of availability
availability of appropriate programs for young, single, poor, and frequently culturally isolated teens

8. The following are frequently cited as gaps in services because their availability is limited:

formal infant and child care, in schools and communities
transitional and permanent housing and emergency shelters
medical care in communities where Medicaid is refused, or reduced fees are lacking
lack of insurance for the poor and near-poor
meaningful help for fathers and male adolescents
case management, outreach and tracking
employment training, pre-employment training and skills development
vocational education programs for females
insufficient voc. ed. programs and alternative education programs

9. Some barriers to care that have been identified include:

poverty, lack of income and insurance
as the lives of many teens are in a state of chaos and disruption, many programs do not have components addressing the needs for stability, continuity, and timely and efficient services
service delivery requirements that include fees, client age, gender, home and family situations, location, hours, parental consent, frequency or duration of permitted service use
service delivery characteristics, including service site, staff attitudes, interpretation of regulations, methods used to provide service components
client characteristics, including motivation, immaturity, family situations, living arrangements, age, cultural differences
service continuity and supportive services in time of crisis and/or transition

10. Service appropriateness must be identified to reduce the mismatch that can occur between the service model or component and the target population. Examples are: service components that do not consider age differences in teens; programs that focus on teen pregnancy and leave the teen mother isolated once the child is born; parenting information that is given during pregnancy, and not when vitally needed after birth, and the teen is caring for the child.

11. Teens have identified that while "soft services" are needed, frequently the teens are attempting to cope with basic survival needs, such as food, clothing, housing, child care, medical care, and other vitally needed practical assistance. These needs are pressing and often create undue stress on teens already under duress. Therefore delays in providing these services should be reduced and/or eliminated.

12. Programs should be put in place, or expanded on, to include male teens and male teen fathers.

13. Community resources, such as volunteers, parent aides and role models, in-kind donations, and other support services should be tapped and utilized.

14. Teen pregnancy and early childbearing often bring further strain to families already under stress, causing further conflicts and draining of limited resources. Teens often need the support of their families, and families should receive supportive services to create positive family relations, and enhance family stability.

15. Service delivery systems should include such services as peer group support and counseling, mentor programs, self-determination and self-esteem counseling, drop-in centers, subsidized phone services to reduce isolation, recreation and other programs outside of those needed for care, decision-making guidance, in-home services, parent aide programs, and respite care for teen parents.

16. Teens should have services that support them during crises periods, and during transitional periods, for continuity of care.

17. Programs and service delivery systems should incorporate in their planning, the developmental needs of teens and their children, and should involve the significant others in the lives of the teens, such as parents and partners.

Health Services

The health needs of adolescents, pregnant and parenting teenagers, their families and children, are discussed throughout this report.

Currently in Massachusetts, health care and health insurance issues are at the forefront, with plans and proposals coming from Governor Dukakis, the Legislature, interested persons and groups, advocates and the public. Finalized plans could directly and indirectly influence and effect the health needs of adolescents and pregnant and parenting teens. Massachusetts has developed some positive approaches to solving health care issues for pregnant and parenting teens, among them Healthy Start and revisions in Medicaid. Groups and organizations, such as the Alliance for Young Families, the Boston Committee on Access to Health Care, Mass. Law Reform Institute, and others, are working with members of the Legislature, to address health needs. Through these efforts, specific recommendations have been, and are being formulated and implemented. These initiatives should receive continued support at all levels. Therefore, the following general recommendations are offered.

1. Preventive health care and adequate health services should be provided to all children, youth, families and individuals who are in need. Services should be equally and uniformly available and accessible.

2. Preventive health services should be provided to adolescents and pre-adolescents in need, in locations that are convenient and accessible, such as schools, communities, and hospitals. Services should target the special needs of teenagers and their children.

3. Interagency cooperation and coordination, in conjunction with school personnel, and community members, are essential in early identification, screening, and the provision of services to high-risk teens and pre-teens. Barriers to cross-agency and interagency coordination should be eliminated.

4. There should be continued support for the expansion of interagency agreements, particularly in special areas of concern such as health care for needy and disadvantaged youth.

5. Specific components of programs such as EPSDT, Healthy Start, MCH, WIC, and others should be identified for expansion of funding and site location, such as in schools. Consideration of the special needs of adolescents is essential.

6. Wherever communities have identified school-based centers as viable and effective site locations for health care, social services, mental health services and other components of multi-service programming, such centers should be established with a range of comprehensive services. These centers should be adequately funded, and should emphasize prevention in all areas of adolescent needs. A full range of health and educational services should be available. The centers should be linked to vitally needed services in the community, and to relevant course content and curriculum in the schools.

7. Funding and technical assistance should be provided to all health service providers to conduct research on the outcomes of services, the characteristics of the population being serviced, the quality of services provided, and identification of components and linkages requiring expansion.

8. All gaps in availability and accessibility of services should be identified and removed in order to have health services uniformly and equally available.

9. Case-finding services, case management, and outreach services to at-risk youth should become vital components in health care systems, in order to assist teens in accessing early and continuous care. These serfices should be provided in appropriate locations, be confidential, and be specifically targeted to the needs of teenagers.

10. Frequently teen pregnancy and early parenthood are viewed from a single-focus- that of being only a health issue. Teen pregnancy should be addressed as a multi-faceted issue, with teens having multi-faceted needs. Agencies should develop policies to integrate services, and to streamline networks and referral systems.

11. Family Life Education and Health Education Programs should be established in all school systems, with linkages to needed community services and resources, in grades PK-12. Such programs should also be established in communities, hospitals, and other sites.

12. All children and teenagers, including pregnant and parenting teens, should be informed, instructed, and be provided with adequate care, regarding sexually transmitted diseases, and other critical health issues. Services should be provided in schools, communities, and other accessible sites.

13. All teenagers, including pregnant and parenting teens, should be provided with aid and information on nutritional issues, and to be advised on how these services can be obtained. Increased funding for services such as WIC should be supported.

14. Teens should have an independent right to seek and obtain medical care and health services, including preventive health services, that are confidential and free, or at low cost, and that are accompanied by counseling services as needed.

15. Adequate, accessible and timely prenatal care is not uniformly available across the state. Gaps should be identified and closed. Many areas are underserved. Even where services are available, certain populations do not avail themselves of these services due to barriers which should be identified and removed.

16. Early access to prenatal care, and continuity of care should be available and accessible to all teenagers requiring such services. Adequate funding is necessary for the provision of these services across the state.

17. Standard health care for the children and babies of teen mothers should be provided and fully funded, along with preventive services. Instruction and counseling on child growth and development and parenting skills education should accompany the health services.

18. Policies and programs should be developed and implemented that focus on preventive and servicing needs for the children of teen parents, who are often at-risk.

19. Specific recommendations regarding Medicaid use, eligibility, and benefits, have been, and are being developed and implemented through the efforts of the State Legislature, the Women's Caucus Task Force on Poverty, and through various groups and organizations. One of these issues is that teenagers should have an independent right to their own Medicaid card. Continued support for these recommendations is encouraged.

Education

1. Educational programs and supportive services should be provided to at-risk and marginal and troubled adolescents and pre-adolescents long before they reach the level of alienation and isolation that causes them to drop out and turn to other behaviors such as becoming pregnant. A full range of preventive educational and alternative educational programs should be available in all school districts, with linkages to community programs.

2. Mechanisms should be in place in schools, linked with community resources, to identify potential dropouts, and to retrieve and return to school those who have already dropped out, or are problem-absent students.

3. Continued support and expanded funding should be provided to all programs involving dropout prevention, comprehensive health education, drug and alcohol abuse prevention, family life education and home economics programs.

4. There should be components such as alternative educational programs, flexible schedules, work-study programs, adapted attendance regulations, open entry and exit procedures, and other possible options in school programming for pregnant teens, and teen mothers and fathers.

5. While MGL Ch. 622, the Equal Education Opportunity law prohibits schools from excluding students on the basis of pregnancy status, often the lack of school-based services, including health and day care services, inadequate or inappropriate educational programs, and other such disincentives often lead to pregnant and parenting teens becoming dropouts. Schools should assess and eliminate these barriers to educational completion.

6. Teen fathers should be included in relevant services and programs that focus on prevention, education and information on parenting, child care and development, health and nutrition, and other such services.

7. Wherever possible, teen parents should be mainstreamed into school programs, with supportive services as needed, in the school and community.

8. School-based service centers should be established and funded in communities and school systems that have identified such centers as effective models and as needed in the community.

9. Peer education programs should be incorporated into school-based programs and curriculum development, along with student boards and councils, and other activities that encourage student participation in a wide range of issue discussions and problem-solving approaches.

10. School systems and the Department of Education should develop and implement linkages with community-based services in a comprehensive network, either located in the schools, or integrated between school and community. Schools should have the support of the community-based resources; community-based programs need the support of school-based resources. Continued support and funding for initiatives between school systems and DSS, DPH, DMG, should be maintained and expanded.

11. School systems should be an integral part of comprehensive service delivery and educational programming in every community. School representatives should be active participants in local needs assessments and comprehensive community plans.

Vocational Education

1. Equal access to programs in vocational education and vocational choices should be available to male and female adolescents.

2. There should be identification of effective service delivery models from the Carl Perkins Vocational Education Act programs, and other vocational education programs, for replication and expanded funding across the state.

3. Some programs have been developed through the Carl Perkins Act to reduce sex bias and sex role stereotyping in vocational education. Support and funding for these programs should continue, and be made applicable to pregnant and parenting teenaggers. The goals of these programs should permeate all vocational education programs and all employment-related programs.

4. There should be continued linkages between vocational education programs and employment training programs, such as the Department of Public Welfare's ET program, and JTPA, with expansion of program sites, and adequate funding.

5. Junior high schools should provide for, and encourage male and female students to participate in, vocational education preparation and pre-employment/job training/vocational choices courses and programs.

6. Supportive services such as day care and transportation for pregnant and parenting teens needing them in order to remain in school, return to school, and complete their education, should be provided to vocational education students.

7. Regional vocational education schools should work in conjunction with their member cities and towns, and with communities represented by the cities and towns, in identifying the needs of teenagers, including those who are pregnant and parenting, in developing school-based service centers, community-linked programs, day care centers, and other supportive programs.

8. Basic skills learning and development should be incorporated in vocational education programs, and job training programs.

9. Case management services should include vocational education students.

10. Vocational education programs should provide community outreach to inform male and female teenagers about program availability, and to aid dropouts in their return to school.

Job Training and Employment

1. Failure to complete high school is highly correlated with underemployment, unemployment, and welfare dependency. Every adolescent in the state should be encouraged and supported in completing their education, as a prerequisite in preparing them for career choices, further education, and a broadening of their opportunities and life options.

2. For many adolescents, especially those who are disadvantaged and poor, school completion is difficult, and often perceived as irrelevant, as a source of failure, or as in competition with having to find a job to survive or supplement family income. There should be programs available to meet the needs of these youth, such as modified school programs combined with pre-employment or job skills training programs, work-study with flexible scheduling, alternative programs that combine basic skills and job training and vocational education, and other types of options.

3. All agencies working with teenagers, including pregnant and parenting teens, should act as liaisons with other agencies, including job training programs, such as ET Choices, Carl Perkins Programs, in providing information and linkages to these programs, and in referring youth to these programs.

4. Expanded funding for such programs as DPW's ET Choices, JTPA, and Carl Perkins, is vitally needed to meet the increasing numbers of youth requiring such programs. Replication of effective models and linkages involving job training and employment preparation is strongly encouraged.

5. Educational and information-sharing programs are needed in schools, agencies, and communities, to help students seek out and obtain school-based or community-based job training, life planning and life options, work-study, alternative education, job preparation, and other opportunities in which they can succeed.

6. Performance standards, entry requirements, and eligibility requirements should be adjusted for certain categories of youth to allow for flexibility according to their needs. A range of levels for tracking would allow for these differences in skills levels, learning styles, educational attainment, and other variations in the characteristics of this population. Many of these youth are among the neediest, and need educational skills development coincidental with job skills development.

7. Potential sources of JTPA programming for adolescents, and pregnant and parenting teens have been identified and should be explored. These are discussed under the section on JTPA- Job Training and Employment.

8. The special needs of pregnant and parenting teens should be considered in program planning and development, along with the need for unique support services. These teens should have subsidized work experience and job training in conjunction with education, day care and transportation, health services and counseling.

9. Wherever possible, job training programs should be implemented on a graduated basis, to allow for a wide range of potential jobs to be matched with a wide range of youth's abilities. Training for occupations should focus on jobs that pay above the minimum wage and that will be an incentive to avoid welfare dependency.

10. Teenagers, including pregnant and parenting teens, should have counseling and support services available during program participation that helps them in gaining motivation and positive attitudes on seeking self-sufficiency and and employment or training or education over a duration of time. Many teens do not have the motivation and self-esteem necessary to sustain educational and job training programs for a long period of time, and require short- and long-term goals development education, information and counseling.

11. Communities, agencies, school personnel, and those working with youth should tap all community resources regarding job placement and opportunities, skills development, work-to-job transitional services, and other related resources.

Family Life Education, Human Sexuality Education, Health Education

1. Educational, informational, and counseling programs concerning life issues such as human growth and development, human sexuality, health education, problem-solving and decision-making skills, life planning and goal-setting, communication and interpersonal relationships, should be uniformly and equally available to all children, pre-adolescents and adolescents in the state.

2. The content, development, curriculum subjects, and format, should be included in a community plan, with participation from students, parents, school personnel, service providers and other community members.

3. Human sexuality education and family life education programs should be presented in the broader area of life planning, recognizing the underlying concept that decision-making about sexuality matters is one aspect of decision-making about future life options. Central to such programs is the

premise that education and accompanying services on human growth and development are essential to youth becoming responsible, healthy, and productive members of society.

4. Programs should be effectively linked with community services, through an efficient referral network. Parental and student participation through group discussions, peer and parental education groups, should be included.

5. A research component should be included in program development and implementation, with effective models identified and replicated.

6. Information and skills testing on subject matter and curriculum content that is age- and grade-appropriate, should be incorporated into statewide curriculum testing, by the Department of Education.

7. There should be continued support for mandated Family Life Education Programs to be established in the public school systems in Massachusetts.

8. There should be support for expanded funding for Comprehensive Health Education Discretionary Grant Programs, through the Department of Education.

Family Planning Services: Counseling, Contraceptive Services

1. Teens who are not sexually active need education, information, and counseling to resist peer pressure, media and other influences, to become sexually active, and support in delaying the onset of sexual activity. Many teens become sexually active long before they are emotionally and cognitively ready to do so.

2. For those teens who are sexually active, family planning services, including information and counseling, peer and group discussions, with parental participation and support, should be linked to other crucial services, such as health education, family life education, and social services.

3. Services should be located in, or linked to, places where youth congregate, and not just in isolated health centers or clinics. Though "free-standing" programs provide positive services, their effectiveness can be improved through linkages and referral networks, and through expanded site locations.

4. Family Planning services should teach crucial preventive strategies to teens, and should be provided in the context of other learning and problem-solving issues confronting teens. Consistent follow-up and continuity of education about family planning through counseling and monitoring of services, are important components in the provision of, and effectiveness of, these services.

5. Family planning services should be targeted to the specific needs and developmental levels of pre-teens and teenagers.

6. Family planning and contraceptive services should be equally available and accessible to male and female adolescents, with accompanying counseling.

7. Programs that include, or are specifically focused on, family planning should be funded to include research on effectiveness, outreach, case management, linkages, community networking, and expansion of sites and locations.

8. Locations for extended family planning and contraceptive services, referral, and counseling that focus specifically on teens, should be included in community needs identifications, assessments, and comprehensive community plans.

9. Family planning services should be affordable, confidential, available, and accessible for all teenagers. Every effort should be made to counsel, inform, and educate youth, in order for appropriate and positive attitudes to develop about sexuality, contraception, pregnancy and childbearing behavior.

10. Pregnant and parenting teenagers need to be targeted for special family planning efforts to avoid subsequent pregnancies. These efforts should include follow-up or support activities designed to promote continued, effective family planning.

Public Assistance Programs

Currently in Massachusetts, there are strong, positive initiatives and efforts being made to address the many and varied issues concerning public assistance programs and their ability to meet the needs of children, youth, and families. Gaps in poverty levels and the capacity of families and individuals to live at an adequate standard of living are being identified, with accompanying recommendations on approaches to closing these gaps. Problem areas in housing, nutrition, adequate food, medical and health care, Aid to Families with Dependent Children, General Relief, Employment and Training, Medicaid, WIC, and other public assistance programs are being examined and evaluated for improvement by the Massachusetts Caucus of Women Legislators, Task Force on Women and Poverty, the Massachusetts Legislature Joint Committee on Human Services and Elderly Affairs, the Up to Poverty Campaign, members of the Legislature, and various groups and organizations and advocates. These initiatives are discussed throughout this report.

In November, 1986, the Women's Caucus Task Force on Women and Poverty issued a report, "Public Assistance Programs for Poor Women in Massachusetts". The report discusses all public assistance programs, the problem areas inherent in these programs, and recommendations to address these problems. In March, 1988, the Joint Committee on Human Services and Elderly Affairs issued a report, "Closing the Gap: Closing the Poverty Gap for 220,000 Children in Need", with accompanying legislation. The report address the issues and problems concerning families living in poverty, especially those dependent on AFDC, discusses the Up to Poverty Campaign, reviews court decisions on public assistance programs, and outlines a three-year plan for closing the poverty gaps. The legislation addresses areas and funding needs for the first year of the plan. There should be continued support for the implementation of the recommendations contained in these reports.

1. Pregnant and parenting teenagers should have an independent right to receive adequate benefits for themselves and their children, regardless of whether they are living at home or independently.

2. The specific and unique needs of pregnant and parenting teens should be addressed, along with the needs of their children, in providing public assistance, whether they are living at home, or independently.

3. Benefits should be increased to a decent and adequate standard of living for pregnant and parenting teens and their children, with adjustments in benefits to meet additional needs required by this population, such as day care for education completion, transition to work, job training and skills development, health care during transitional periods to self-sufficient status, transitional periods during changes in living arrangements, and other areas unique to this population.

4. Needy pregnant and parenting teens who live with families who do not qualify for public assistance, should be evaluated in their own right for need and eligibility, and should receive adequate benefits and assistance to meet their individual needs.

5. For pregnant and parenting teens living at home, need levels should be considered in relationship to the needs of the family, especially regarding the additional stress and instability a teen pregnancy can have on a family already under duress.

6. Pregnant and parenting teens should have public assistance services that are linked to other vitally needed services, such as housing arrangements, nutritional services, education and job training, and health care.

7. Demonstration projects should be evaluated for possible implementation and replication that focus on separate tracks within public assistance programs such as AFDC. Benefits and services could be adjusted to meet the needs of teens whose life situations place them within a specific track, and whose needs would therefore vary. Tracks would consider services and benefits relating to teens returning to school, those who are in transitional periods, those enrolling in job training, those who live alone or in shared housing, etc.

8. Pregnant and parenting teenagers and their children who are recipients of public assistance services should receive case management services, and be informed of other services and benefits available, through a streamlined referral network that would include day care, prenatal care, work-study, nutrition programs, and other such needed services.

Housing and Shelter

1. Whenever possible and feasible, pregnant and parenting teens, and their children should be encouraged to remain in their family living situation, with support services available to all family members.

2. There should be expanded funding for affordable housing units for pregnant and parenting teens and their children, with components built-in, and support services available to address the specific needs required.

3. There should be expanded funding for increased Transition to Independent Living Programs for pregnant and parenting teens, by site in areas of the state, and by needed services within each site.

4. Models for a variety of housing and living arrangements for pregnant and parenting teens and their children should be explored, with effective models initiated and replicated. Models would include shared housing units, supervised group care, shelters, specialized foster care, and other alternative living models. All agencies should form agreements for evaluation, research, services needed, funding and implementation of effective models for those teens who are unable to live with their families.

5. Frequently pregnant and parenting teens are faced with disincentives to remaining with their families, or are forced to leave their family home, such as when family size increases beyond public housing regulations due to a teen pregnancy. These problem areas should be addressed and remediated.

6. Waiting periods for subsidized housing for teens and their children should be reduced and eliminated.

7. Pregnant adolescents should be allowed to apply for public housing before the birth of their child, so that the application process can be facilitated, and disruptions and transitions can be reduced during pregnancy and after the birth of the child.

8. A problem identified by service providers regarding specific housing needs is that Section 8 certificates for subsidized housing are not provided to teens who want to, or need to, share in group housing. This area should be evaluated, and appropriate changes should be made.

Child Care

1. The initiatives and recommendations of agencies, such as EOHS, DSS, DPW, and groups and organizations such as the Alliance for Young Families and day care coalitions, and those put forth by the State Legislature should be supported, funded and implemented.

2. High quality child care for teen parents should be provided, with expanded funding for increased slots in areas across the state, and in convenient sites, such as schools, communities, and within program structures.

3. Specialized services and components should be incorporated in day care programs to meet the needs of pregnant and parenting teens, such as transportation, parenting education, child growth and development, nutrition services, and other services unique to this population.

4. Expanded funding and increased slots are needed for teen parents:

Family Day Care	DSS contracted day care
school-based day care	Young Parents' Programs
center-based day care	JTPA discretionary funds
Supportive Services day care	DPW ET

5. The feasibility of providing day care services in certain supervised shared housing situations, or transition to independent living programs, and other living arrangements should be researched and funded.

6. As many teen parents need day care on a part-time basis, the use of shared slots should be evaluated.

7. Case management, outreach, and advocacy should be provided to those teens requiring day care services accompanying participation in other programs, such as job training, education, work-study, etc.

8. Specific social services should be provided to teens requiring them, within the day care program, and accompanying the day care program, such as respite care, financial assistance, in-home services, etc.

9. Support services should be provided to the families of teen parents who are caretakers of the teens' children. Financial assistance should also be provided to family members who are caretakers of teens' children.

10. As the ability of teen mothers to utilize education and work programs is often dependent on child care, day care services should be an integral part of these programs.

Social Services

1. There should be increased funding for expansion of DSS Young Parents Programs: by extended site locations across the state; by types of programs such as community-based and school-based; and by expanded service components within each site. Funding should be appropriated for continuation of effectiveness studies on program models and client outcomes.

2. Mechanisms and support services should be in place in all programs to help teenagers at-risk to identify the potential for child abuse and neglect, and the presence of child abuse and neglect. Services could include counseling, education, including parenting education, practical and concrete assistance during stressful times, linkages to other needed services, and other services.

3. There should be support for expanded funding to increase services such as counseling, parent aide, in-home services, recreational programs, mentor programs, life planning skills development, and other needed services, for pregnant and parenting teenagers. Gaps in these services across the state should be identified and remediated.

4. The children of teenagers should be targeted for preventive social services, with integrated and coordinated service systems available to meet the often complex needs of these children and their teen parents.

GENERAL RECOMMENDATIONS

1. Embody effective prevention strategies in a systematic network of support systems and services that promote positive youth and family development.

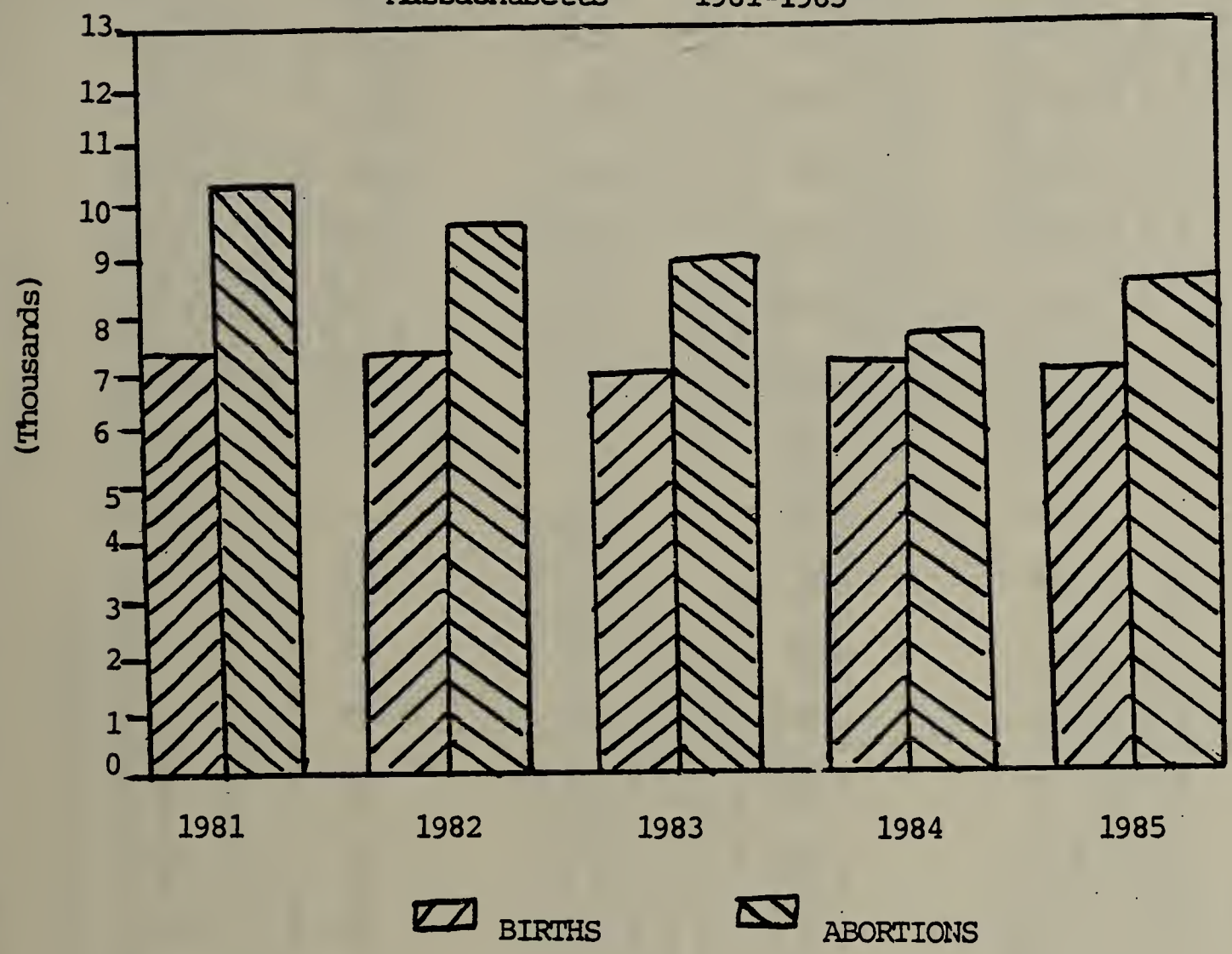
2. Broaden and enhance the life options and opportunities of every child and adolescent. These strategies would ensure: the basic needs of every person would be met; educational and economic equity for males and females; equity and equality of services with respect to gender, cultural, and ethnic group identity.

3. Mandate Family Life Education Programs in all school systems in the Commonwealth, with linkages to community-based and other school-based programs.

4. Develop and implement comprehensive community plans to meet the needs of children, youth and families. The plan would identify resources, identify the target population, and include needs assessments. Comprehensive integrated servicing networks should be developed to meet the identified needs and gaps in services.

5. Conduct short- and long-term research studies and evaluations on program content, quality of service delivery, format, duration, the needs of the population serviced, location, and effectiveness.

TABLE 1



Graphics: Joseph Foti

	Births	Abortions
1981	7,429	10,381
1982	7,361	9,520
1983	6,919	8,881
1984	7,016	7,522
1985	6,970	8,354

Recently available 1986 figures from DPH; births- 6851; abortions- 9,814

Total Teen Births: 1985 6970 1984 7016 TABLE 2 Teen Birthrates: 1985 30.3 1984 29.3

RANKING OF 25 MASS. CITIES AND TOWNS FROM HIGHEST TO LOWEST
NUMBERS OF BIRTHS TO ADOLESCENTS, AGES 12-19 YEARS, SCHOOL AGE 12-17 YEARS

City, Town	12-19 years 1985	12-19 years 1984	12-17 years 1985	12-17 years 1984	%Total Births of City,Town 1985	%Total Births of City,Town 1984
Boston	1192	1132	468	438	13.3%	13.2%
Springfield	418	504	175	198	15.8	19.2
Worcester	316	312	116	101	12.0	12.9
Lawrence	273	246	100	101	18.0	18.8
Lowell	261	248	86	92	14.9	14.4
Brockton	242	226	89	72	13.9	13.9
Fall River	240	234	74	75	17.5	16.9
New Bedford	223	232	81	79	15.0	15.7
Holyoke	188	141	74	63	23.3	18.8
Lynn	173	156	60	69	12.6	11.8
Fitchburg	100	80	28	20	15.0	13.5
Somerville	85	78	21	19	8.2	7.8
Haverhill	83	93	32	31	10.5	12.3
Taunton	77	94	29	38	11.3	13.0
Pittsfield	69	78	20	25	10.7	11.4
Chelsea	69	58	21	38	13.9	12.1
Cambridge	68	60	32	24	6.0	5.5
Chicopee	62	72	22	32	8.3	9.4
Leominster	62	58	15	17	11.0	11.3
Attleboro	57	63	19	19	10.0	11.0
Quincy	57	54	15	14	5.4	5.4
Weymouth	44	48	11	19	6.5	7.0
Southbridge	43	44	11	16	16.6	17.6
Salem	39	49	13	20	7.9	9.3
Westfield	39	51	11	15	8.4	9.9

TABLE 3

ATTITUDES, MOTIVATIONS, AND BEHAVIORS THAT AFFECT THE PROBABILITY OF UNINTENDED PREGNANCY & WELFARE DEPENDENCY

STAGE	ATTITUDES, MOTIVATIONS, AND BEHAVIORS	
1. ENGAGE IN SEXUAL ACTIVITY	a. No/low alternatives or future goals b. Ignorance of consequences c. Inability to plan d. Peer pressure, including attracting and keeping partner e. Ignorance of level of poor sexual activity f. Inability to discuss with significant other g. loneliness	h. Low self-esteem i. Bad relationships with parents j. "Pro-love cultural stimuli k. "Pro-sex" cultural stimuli l. Fun, excitement m. Double standards, sex role stereotyping n. Confirmation of attractiveness o. Support for sex-role identity
2. CONTRACEPTIVE USE	a. Ignorance of lack of cognitive maturity to understand: physiological processes, contraceptive techniques, consequences of pregnancy, probability of pregnancy b. Positive valuation of pregnancy or associated status: adult status c. Fear of parents finding out, losing partner, talking with partner d. Actual negative side effects of contraceptives use: feared side-effects of contraception	e. Erratic sexual activity schedule: unexpected sex f. Availability of contraception: cost of contraception g. Denial of sexual activity: guilt h. Ideology (it's not natural; sex should be spontaneous i. Risk-taking j. Thoughtlessness: lack of planning k. Inconvenience of contracepting l. Fear of embarrassment of physical examination
3. BIRTH AND RETENTION OF OUT OF WEDLOCK BABY	a. Denial of pregnancy b. Unacceptibility of abortion to self, family, baby's father, community c. Unacceptibility of adoption to self, family, baby's father, community d. Positive valuation of motherhood and having baby e. Good support system for child care f. Baby fulfills (at least temporarily need for attachment, being needed, purpose in life, loneliness abatement, rivalry with own mother or siblings	g. Greater acceptibility of non-marital childbearing h. Welfare availability (for some) i. Bond with baby's father j. Poor performance in other roles (e.g. school failures) k. Acceptance of motherhood is punishment (you made your bed, now lie in it) l. Adult status m. No/low understanding of difficulty of parenting

Source: Private Crisis, Public Cost, Moore and Burt, 1982, Ch. 10

TABLE 3 (cont'd)

4. MARRIAGE AND BIRTH	a. Social/moral preparation for marriage b. Adult status of marriage c. Marriage secures relationship with baby's father: love d. Dependency (can't support self and baby without marriage)	e. Already had marriage plans f. Father unemployed, uses drugs, in jail, already married
5. WELFARE DEPENDENCY	a. Low job skills b. Incomplete education c. Subsequent births d. Poor or nonexistent child care	e. Poor job training and remedial educational programs f. Poor job-search and self-presentation skills g. Lack of jobs that provide wage and fringe benefits for self-support h. Traditional attitudes regarding material employment

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